

Health Care Financing Extramural Report

Nationwide Evaluation of
Medicaid Competition Demonstrations

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Extramural Report

The Office of Research and Demonstrations, Health Care Financing Administration, directs more than 300 intramural and extramural research, demonstration, and evaluation projects. The projects seek alternate ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. The Health Care Financing *Extramural Report* series represents the final reports from selected extramural projects funded by the Office of Research and Demonstrations. The statements and data contained in each report are solely those of the awardee and do not express any official opinion of or endorsement by the Health Care Financing Administration.

In the 1982, the Health Care Financing Administration approved funding for demonstration programs in six States to test a variety of alternative delivery strategies for Medicaid recipients. A number of innovative health service delivery features were used in these programs, including competition, capitation, case management, and limitations on provider choice to address the key Medicaid problems of cost containment and access to appropriate and high quality care. The case studies provide indepth examinations of how the demonstration sites have approached the task of designing, planning, staffing, and implementing their various programs.

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PREFACE

The Nationwide Evaluation of Medicaid Competition Demonstrations is a multi-year in-depth evaluation incorporating case studies and analysis of primary and secondary data in order to evaluate implementation, operation, cost, utilization, quality of care, access, and satisfaction issues, among others, for the Medicaid Competition Demonstration Projects being conducted in six states through demonstration grants from the Office of Research and Demonstrations of the Health Care Financing Administration (HCFA).

This document includes a second year case study overview and the set of second year case studies for the Medicaid Competition Demonstration Projects. The case studies were carried out by the American Enterprise Institute, Lewin and Associates, and New Directions for Policy under subcontract to Research Triangle Institute (RTI).

Volume I presents the second year case study overview for the demonstrations. Volumes II through VII are the individual case studies, presented alphabetically by state. Volume II is for the Santa Barbara County (CA) Special Health Care Authority, commonly referred to as the Santa Barbara Health Initiative. Volume III is the final case study for the Monterey County (CA) Health Initiative, which is now terminated, with return of the county to regular Medicaid (Medi-Cal) program status. Volume IV is also a final case study for the set of Florida demonstrations, known as the Florida Alternative Health Plans. Volume V is for the three-county (urban, suburban, and rural) Minnesota Prepaid Medicaid Demonstration. Volume VI is for the Missouri Managed Health Care Project being implemented in Jackson County (Kansas City) Missouri. Volume VII is for the New Jersey Medicaid Personal Physician Plan, in the process of statewide implementation for New Jersey. Finally, Volume VIII is for the Monroe County, New York, MediCap program being implemented for the Rochester, NY, area.

The views expressed in the overview and case studies are solely those of the respective authors, and do not necessarily represent the position of or endorsement by the Health Care Financing Administration.

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Evaluation of Medicaid Competition Demonstrations

Volume I

Overview Of Year Two Case Studies

by

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CHAPTER ONE

INTRODUCTION

The purpose of the demonstrations and the role of the case studies are discussed and the objectives and format of this overview are presented. The individual programs are briefly described and key terms defined.

The Health Care Financing Administration (HCFA) approved for funding in 1982 demonstration programs in six states to test a variety of alternative delivery strategies for Medicaid recipients. The programs are using a number of innovative health service delivery features including competition, capitation, case management, and limitations on provider choice to address the key Medicaid problems of cost containment and access to appropriate and high quality care. The demonstrations have incorporated these features into several different types of organizational arrangements to test a number of assumptions about how the delivery system can be effectively changed.

In the fall of 1983, HCFA awarded a contract to conduct a four-year evaluation of these demonstration programs to a consortium of researchers under prime contract with the Research Triangle Institute*. This evaluation is designed to perform a comprehensive assessment of the case management strategy including implementation and operational issues

*The consortium also includes the University of North Carolina-Chapel Hill, Medical College of Virginia, Lewin & Associates, American Enterprise Institute, and Tillinghast, Nelson & Warren.

as well as program outcomes. The evaluation plan includes both quantitative and qualitative components to accomplish this goal.

The analysis of program effects using such outcomes as cost, use, access, quality, satisfaction and provider participation will be conducted with primary, e.g. surveys, and secondary, e.g. claims, data collected during operation of the programs. The evaluation team is examining design, development and implementation issues primarily through a series of detailed, multi-year case studies carried out at each of the demonstration sites. This overview describes the set of second round case studies performed in the sites. The final report of the evaluation is due in 1987.

Purpose of the Demonstrations

The demonstration programs are exploring whether these alternative approaches to providing care can respond to the many problems which have plagued the Medicaid program during its twenty years of existence. These problems include, but are not limited to, the following:

- Excessive rates of cost increases
- Unnecessarily high rates of use for selected services
- Inappropriate patterns of use such as:
 - Over reliance on the emergency room for non-emergency care

- High rates of self-referrals to specialists
- "Doctor shopping", or capricious changes in medical providers
- Lack of access to providers offering continuity of care
- Concern that available providers may not provide high quality care
- Declining physician participation for such reasons as:
 - Unreasonably low fees
 - Delays in receiving payment on a timely basis
 - Administrative burdens in negotiating the payment system

Many of these problems are interrelated and self-reinforcing, suggesting major structural reform must be explored in the Medicaid program. These demonstrations with critical elements of competition, capitation and case management are among several delivery system reforms currently being evaluated by HCFA.

The competitive dimensions of these programs are based in attempts to bring into Medicaid participation providers who have traditionally had little or no involvement with the program. By expanding provider participation, problems in access can be addressed and, ultimately, costs may be contained and reduced by increased competition among new and existing providers. In response to the entry of new providers, traditional Medicaid providers are expected to modify their approaches to serving this population to avoid loss of patients.

Financial risk-sharing with providers in the form of prepaid

capitated rates is also being explored extensively in the demonstrations. The setting and payment of rates in advance to cover specified services gives participating providers concrete performance targets which they must meet to remain viable. By establishing rates below existing equivalent fee-for-service payment amounts, the demonstration programs can be assured of cost savings. Correspondingly, prepayment gives providers increased predictability of revenues and improved cash flows. More significantly, providers come to recognize that substantial financial savings might be achieved by judiciously managing enrollee utilization including limiting unnecessary use and substituting less costly services.

Case management attempts to address cost, use, and access problems by taking advantage of the pivotal role of the primary care provider as the point of access to the health care system. By linking and "locking-in" an eligible person to a primary care case manager who can both provide and manage a substantial portion of a recipient's medical care, patterns of service use may be changed and access to appropriate care assured. The relationship of the provider to the Medicaid program and to the recipient can be structured with contractual arrangements and risk-sharing approaches in a number of ways which are designed to foster effective case management and to achieve program goals. The demonstrations represent a broad spectrum of planned variations intended to do this.

The Role of the Case Studies

The case studies are designed to provide in depth examinations of how the demonstration sites have approached the task of designing, planning, staffing, and implementing their various programs. The first round of studies, performed during the first year of the evaluation, involved numerous interviews with key state and local officials and administrators, providers, consumers, and other interested parties during the period when most programs were in their early stages of development and implementation. They examined the context of program design including the political and market conditions which had contributed to interest in Medicaid reform in general, and the strategies employed in the demonstrations in particular.

Because of the variations among the programs, the case studies offer important insights into the complex problems and opportunities faced by program participants. Many of these issues are similar across sites and were anticipated. Other issues have arisen because of unique features of the local environment or specific program design characteristics which have produced unanticipated developments. Several of these issues were outlined in the first year studies and their overview.

The second round of studies, conducted approximately one year following the first round during 1985 and 1986, continued this

attempt to identify and interpret developments which have emerged as the programs have progressed from inception to operation. They report on why and how some programs have matured and grown while others have struggled or been terminated, again noting the similar and different challenges faced at each site. Thus, to appreciate fully the evolution of each program it is useful to read the two years of case studies for the sites in tandem.

Purpose of this Overview

This overview of the second round case studies attempts to draw together in a systematic way the status of the demonstrations at the time when the second round study was completed. The status of each varies substantially due to the differing pace of program development and the timing of the second round visits, which were mutually determined by the sites and the evaluation team. Consequently, rather than being a progress report on all sites at the same point in time, it summarizes program development at the time when the second round study was completed. The differences will be detailed in the discussion which follows.

The overview begins with a general update of the status of the demonstration sites. It then discusses in summary form several significant developments and design changes which occurred during the second year case study time period. The status of selected key issues are reported by drawing on

the experiences across the sites. Finally, key issues which are expected to emerge in year three and thereafter are presented.

Brief Descriptions of Individual Programs

An appreciation of the development of the programs requires some background on the individual demonstrations. Detailed program characteristics may be found in the case studies, but a brief description is presented below.

Santa Barbara. This demonstration, operated by the Santa Barbara County (California) Health Initiative under a prepayment contract with the state Medi-cal agency, is a mandatory primary care case management program. The Initiative contracts on a prepayment basis with such primary care providers as individual physicians, physician groups, and health centers, which then are responsible for providing primary care services and for authorizing specialty and hospital care.

Monterey. Operated by the Monterey County (California) Health Initiative until its termination in March 1985, this demonstration also provided a mandatory primary care case management program. Unlike the Santa Barbara program, the primary care providers were paid on a fee-for-service basis with a case management fee and were not at financial risk for specialty and hospital care. Participating providers included physicians, health centers, and hospital outpatient departments.

Missouri. The state Medicaid agency operates a mandatory enrollment program for Aid to Families with Dependent Children (AFDC) recipients of Jackson County--the Kansas City area. Most of the eligible population is enrolled with five pre-paid health service organizations: two hospitals, two neighborhood health centers, and an individual practice association (IPA) which are responsible for providing and/or authorizing virtually all medical care. Approximately twenty percent of the eligible group are enrolled with primary care physicians who are paid on a fee-for-service basis and receive a case management fee to manage care, including authorizing referral and inpatient services.

New Jersey. This demonstration provides for the voluntary enrollment of Medicaid eligible individuals with primary care case managers--physicians and health centers--which are paid on a prepayment basis for each enrollee. The prepayment is structured to compensate the case manager for primary care services directly provided, and to place the case manager at some financial risk for referral services. Operated by the state Medicaid agency, the program has been implemented in several counties and state-wide implementation is planned.

New York. This mandatory program in Monroe County--the Rochester area--is managed by a county agency under a pre-payment contract to the state Medicaid agency. This agency,

MediCap, contracts with a network model health maintenance organization (HMO) to provide case-managed services to the enrolled population. The provider members of the network include physician groups, neighborhood health centers, and hospitals which receive prepaid amounts to cover a broad range of medical services which are either provided or arranged.

Minnesota. The state Medicaid agency is conducting demonstrations in three counties: Itasca, Dakota, and Hennepin (Minneapolis). In Itasca, a small rural county, the county receives a prepayment for each enrollee and providers are paid on a fee-for-service basis with surpluses and deficits shared by the county and the providers. In Hennepin and Dakota (a suburban Minneapolis county) seven health organizations have entered into prepayment contracts to enroll eligible individuals who may select from any of the plans. Enrollment is mandatory in the counties with the exception of Hennepin where only 35 percent of the population will be randomly assigned to enrollment and the remainder will stay in the traditional Medicaid program.

Florida. Four separate modules were originally planned by the the state Medicaid agency to develop alternative delivery systems using elements of prepayment, competition and case management. Three of the four modules are no longer part of the demonstrations, having been either terminated or undertaken by the state as non-demonstration programs. Planning for the fourthg module continues and involves the development of a prepaid, case management

program for the frail elderly. This program is anticipated to be implemented in 1986 in the Miami area and its objective will be to avoid nursing home placement by the provision and coordination of medical and social services.

Further detail on these programs may be found in Appendix I.

Key Terms Used in this Overview

The variations in program design permitted and encouraged in the demonstrations make it important to clarify several terms used to describe certain program aspects across the demonstrations. Among the key terms and their definitions are the following:

Risk Assuming Intermediary. In two states, California and New York, intermediary organizations have contracted with the state Medicaid agency to manage the program in return for a fixed prepaid amount received for each eligible person enrolled in the program. These intermediaries, which provide no medical services themselves, are responsible for arranging service provision with area medical providers.

Prepaid Health Plans or Organizations. These provider organizations enter into agreements either directly with the state Medicaid agency or the risk-assuming intermediary organization to provide services. These organizations may range from conventional prepaid organizations like HMOs to other

providers such as hospitals and health centers and are typically paid on a prepayment basis for a specified range of services.

Primary Care Case Managers. In several of the programs primary care physicians are formally designated as the case manager or "gatekeeper" for a group of enrollees. Case managers may have contractual relationships with the Medicaid agency, intermediaries, or prepaid health plans and may be compensated by a prepaid payment for specified services, or on a fee-for-service basis. In fee-for-service situations, the case manager is usually paid a supplemental fee to perform case management duties. Some of the participating prepaid plans have elected to use the case management approach while others have not.

Capitation. Programs have established prospective rates of prepayment which are based on the average historical cost to provide a specified set of services to eligible individuals. These rates, called capitation payments, represent the principal means of structuring risk-sharing among the various organizations participating in each demonstration. The capitation rate may be set to include all Medicaid services or they may be limited to a subset of them such as primary care services.

CHAPTER TWO

UPDATE ON THE DEMONSTRATION SITES

The status of each demonstration at the time of the second round case study is reviewed.

The first year overview described how each of the programs was designed including: organizational structure, participating eligibles, covered services, eligible providers, payment systems and provider incentives, rate setting, and the administrative/managerial functions of the programs. In addition, it provided a description of the waiver process and the specific waivers which had been granted to each site to enable it to develop the program envisioned.

Table I-1 provides a synopsis of the principal program features to allow for some comparison and contrast across these diverse demonstrations. To aid in appreciating the differing rates at which program development has proceeded, Table I-2 presents a timeline for each of the sites which identifies when the programs were approved, implemented, or terminated through July 1, 1986. The sharp variations in time from authorization to implementation are discussed in detail in the case studies.

Significant development occurred in each of the sites during

Table I-1

Selected Demonstration Characteristics

Demonstration Site	Date of Implementation	Type of Enrollment ^a	Organizational ^a Structure	Eligible Population	Participating Providers	Provider Payment
<u>California</u>						
Monterey County	June, 1983 (a)	Mandatory enrollment;	Risk-assuming intermedian which contract with primary care organizations and individuals	Categorically eligible and medically needy	Case Managers are primary care provider including physicians, clinics and hospitals	Intermediary capitated Monterey-FFS plus fee -SB-capitation
Santa Barbara Co.	September, 1983	choice of provider				
<u>Minnesota</u>						
Hennepin County	December, 1985	Mandatory (b) Enrollment;	State contracts with Prepaid Health Plans or County (Itasca)	AFDC, AGED, Blind, Disabled	Primary care Organizations	Capitation to plans in Hennepin and Dakota and to county in Itasca
Dakota County	December, 1985	Choice of provider				
Itasca County	August, 1985					
<u>Missouri</u>						
Jackson County	November, 1983	Mandatory Enrollment; choice of provider	State contracts with Prepaid Health Plans and individual physicians	AFDC	Plans include hospitals, IPA, neighborhood health centers and individuals for physicians	-Capitation for prepaid health plans -FFS with fee for physicians
<u>New Jersey</u>						
	June, 1983	Voluntary Enrollment	State contracts with primary care organizations and individual physicians	Categorically eligible	Case manager must be primary care provider including health centers and physicians	Capitation
<u>New York</u>						
Monroe County	June, 1985	Mandatory enrollment; choice of provider	Intermediary which contracts with prepaid health plans	AFDC, Home Relief, Medically needy	Prepaid health plans	Capitation
<u>Florida (c)</u>						
	Planned	Voluntary Enrollment	State Contracts with prepaid plan	SSI-frail elderly	Hospital	Capitation

Notes:

- (a) Terminated March, 1985.
- (b) Random assignment employed in Hennepin County.
- (c) Three of four proposed modules terminated August, 1984.

TABLE I-2

SITE DEVELOPMENT AND IMPLEMENTATION SCHEDULES

1-1-82 1-1-83 1-1-84 1-1-85 1-1-86 1-1-87

|-----|-----|-----|-----|-----|-----|

Santa Barbara [-----] [-----] [-----] [-----] [-----] [-----]

4-82 Approval 9-83 Operational

Monterey [-----] [-----] [-----] [-----] [-----] [-----]

4-82 Approval 6-83 Operational 3-85 Terminated

Missouri [-----] [-----] [-----] [-----] [-----] [-----]

6-82 Approval 11-83 Operational

New Jersey [-----] [-----] [-----] [-----] [-----] [-----]

6-82 Approval 7-83 Ph I Operational 8-84 Ph II Operational

New York [-----] [-----] [-----] [-----] [-----] [-----]

6-82 Approval 6-85 Ph I Operational

Minnesota [-----] [-----] [-----] [-----] [-----] [-----]

6-82 Approval 8-85 Itasca Operational 12-85 Hennepin, Dakota Operational

Operational

Florida [-----] [-----] [-----] [-----] [-----] [-----]

6-82 Approval 8-84 3 Modules Terminated Module C Planning

the interval between the first and second case studies and it is useful to summarize the status of each site when the second case study was completed.

- Santa Barbara.** This program has completed enrollment of its target population and achieved a stable operational system. Program managers report generally positive financial results and provider attitudes during its first year and one half of operation.
- Monterey.** This program was terminated due to insolvency in March 1985 and the traditional Medi-cal program has been restored.
- Missouri.** This program, which is limited to Jackson County, has also completed target enrollment and reports general recipient and provider satisfaction.
- New Jersey.** The program was expanded from rural pilot projects to a group of urban counties but has undergone several operational changes, the results of which are not yet clear; program expansion has stopped and a number of critical issues remain to be resolved before the program can move ahead.
- New York.** This program has grown substantially in enrollment after a late start though provider participation remains limited to a single HMO network and further recruitment are planned for the future.
- Minnesota.** After lengthy negotiations, the program has finally been extended to Hennepin and Dakota counties where a number of interesting program elements are being explored. The program has been operational in a small rural county, Itasca,

since August 1985 and began in the others in December 1985.

--**Florida.** The multi-module program planned will not be implemented. Planning continues on the development of a prepaid case management program for the frail elderly which is expected to be carried out with a Miami hospital.

Table I-3 presents a summary of the recipient enrollment and plan/provider participation at each site at the time noted.

These demonstrations are being undertaken in a volatile health services environment. Many issues such as other public program reforms, competitive initiatives in the private sector, and explosive growth of various types of alternative delivery systems have both direct and indirect impact on the demonstrations in general and on certain aspects in particular. Consequently, program managers feel intense pressure to address on a continuing basis how they can best modify their programs to make them both viable and successful under conditions of considerable market flux and uncertainty.

TABLE I-3

PROGRAM ENROLLMENT AND PLAN/PROVIDER PARTICIPATION

SITE	REPORTING DATE	ENROLLMENT	NUMBER OF PARTICIPATING PLANS AND PROVIDERS
Santa Barbara	March 1985	20,800	125
Monterey	December 1984	26,000	160
Missouri	August 1985	22,907	59
New Jersey	June 1985	9,509	219
New York	February 1986	25,020	1 Network HMO with 12 members
Minnesota	July 1986	8,067	7

CHAPTER THREE

SIGNIFICANT DEVELOPMENTS AND DESIGN CHANGES

Important program developments in each site between the first and second year case studies are summarized. Changes made in program design during this interval are reported

Site-Specific Developments

The second round of case studies indicates that this period has been marked by important developments at each site.

For **Santa Barbara** and **Missouri**, the most mature of the demonstrations, this was a time, primarily, of program refinement with increased sophistication evident in a number of program characteristics. Because of this maturity and the expectation that the states will request permission from HCFA to continue operation after the demonstration ends as discussed below, attention has focused on their long term viability including, especially, the importance of rate setting.

For the programs which had long start-up periods, such as **New York** and **Minnesota**, the second year case studies report the consensus-building and trade-offs required to finally launch these demonstrations. The two sites also contrast the dilemma faced by all programs of trying to get the

programs started quickly while attempting to recruit a broad spectrum of providers. New York opted to implement with a single provider network while Minnesota waited until a number of providers agreed to participate. In **New Jersey**, the issue of provider recruitment also emerged as the program expanded to urban areas and patients were primarily enrolled with case managers who already were long-standing, high volume Medicaid providers.

The **Florida** and **Monterey** programs illustrate the vulnerability of the demonstrations to both controllable and uncontrollable circumstances before and after implementation. In Florida, a highly ambitious, multi-faceted program was unable to be implemented as intended within expected time frames. A complex web of constraints including but not limited to program credibility, provider resistance to unreasonably low capitation rates; state inexperience with prepayment programs and provider negotiations; and the inability of the demonstration to compete successfully with other emerging opportunities for prepaid providers such as enrollment of Medicare beneficiaries, contributed to the failure to become operational.

The Monterey program operated for approximately one and a half years before being dismantled in insolvency. Again, the reasons for its demise are complicated and subject to some dispute, but a number of issues are apparent and can be characterized as design and operational flaws:

Design Flaws:

- To overcome provider resistance to the program, liberal incentives were granted which minimized provider risk
- Many providers were paid more under the program than under Medi-Cal, making savings very difficult
- Expectations of sharp reductions in use were unreasonable, given program design and already low use rates in area
- Though needed to compensate for the absence of financial risk sharing, utilization control systems were not implemented until too late

Operational Flaws:

- The program was implemented without an adequate management information system
- A prior authorization system to aid the case manager in coordinating services by other providers was not implemented until the second year
- Enrollment and utilization data were often inaccurate or unavailable on a timely basis to case managers
- State and Initiative relationships were not conducive to identifying and resolving disputes in an expeditious manner

Developments Common to Sites

Some general developments were evident across most of the sites. Rate setting emerged as a major concern as program managers and providers began to shift their attention from beginning operations to examining the financial impact of the demonstrations. As

discussed below, rate setting problems appear to be confounded by the effects of other system reforms going on in health care, such as Medicare's prospective payment system, intensified utilization management programs by third party payers, and public and private competitive bidding initiatives. These reforms are, in effect, altering the cost baselines used for comparison of program costs (usually the fee-for-service equivalent). Also occurring in most sites is growing competition among providers to protect or expand market share, or negotiate rates which will provide an opportunity to realize a gain. Further, because of the lag time in claims processing and analysis, most programs still only have anecdotal information available on program cost impact.

The sites also report that the enormous problems with management information systems they initially experienced are being solved as the sophisticated systems originally envisioned are finally being effectively implemented. This becomes an especially important issue as providers learn their program responsibilities and grow reliant on timely, detailed information to perform these functions successfully. Program managers and providers continue to indicate that recipients' understanding of their responsibilities in a case management system need reinforcement though learning effects are evident. For example, initially recipients did not understand the limitations on choice of provider in the program and they continued episodic use of inappropriate sources of care such as emergency rooms. However, as the programs have expanded their education efforts, enrollees now appear to have a better

understanding of their responsibilities and out of plan use seems to have subsided.

A final indication of progress is that most sites are now developing systematic programs for utilization review and quality assurance. As detailed in the first year overview, most of the demonstrations did not have management information reports thus causing delays in utilization and quality review programs. However, by the second year some programs began to perform exception auditing and some on-site medical and financial audits to assess compliance with selected medical criteria. Most of these efforts are still focused on utilization review. Quality of care monitoring is still in embryonic form except in the most mature sites but has become a priority area for program managers as they move beyond program implementation.

Second Year Program Design Issues in Continuing Programs

Unlike the first year, in which major design changes occurred, often to enable a program to become operational, the changes being made in the second year at most sites were much less substantial. These issues and/or changes are summarized for each of the programs.

Santa Barbara. The basic program design remained unchanged and is expected to be maintained as this program seeks authorization from HCFA to continue as the county's Medi-Cal

program when the demonstration ends. Two areas which received significant attention during the period were the design and implementation of a quality assurance program, which is still being hampered by problems with management information systems (MIS), and rate setting negotiations with the state. This latter point including the treatment of administrative costs within the rate setting process has been the source of considerable conflict between the state and the Initiative. The problem is intensified because of a number of changes which have been made in the overall Medical program, the fee-for-service (ffs) base has actually been declining and the Initiative has sought unsuccessfully to have its capitation payments raised.

Missouri. Like Santa Barbara, the basic program has proven operationally feasible and the continuation plans call for few design changes. Once the plans were operating, state personnel were able to devote more time to quality assurance, patient education, rate setting and MIS issues. The required completion of "pseudo-claims" by capitated providers remains a source of friction with some providers since they believe these claims are required to be completed primarily for program evaluation purposes rather than for payment. In addition, the state has introduced provider-based cost reporting systems designed to prepare the baseline for use in ultimately converting to plan-specific capitation rates. A final area of development is increased managerial sophistication among providers. Many of the participating plans are seeking to curb out of plan use, to assess their financial position with the demonstration,

and to determine if they wish to expand their enrollments via inter-plan competitive marketing.

New Jersey. Three important issues arose in year two in the only voluntary enrollment demonstration:

- Expansion to urban counties (Phase II) was accomplished with reliance on a limited number of large volume Medicaid providers
- Assumption by the state of several program responsibilities previously contracted out, resulting in severe strain on administrative manpower in the demonstration
- Permission granted to individual primary care case managers to do patient recruitment in their offices

The first of these issues was planned for but it appears that in the interest of expediting implementation, the program has largely only substituted prepayment for fee-for-service payment to traditional urban Medicaid providers. This has resulted in high rates of concentration with a few providers, with one-third of all enrollees with one Newark partnership and another quarter with five health centers in Essex County.

The state experienced an unsatisfactory relationship with the PSROs/PROs as brokers which were to recruit providers and monitor utilization, quality and satisfaction. The state finally terminated that relationship and assumed these duties. Problems with the program's information systems contractor also resulted in termination of that contract and the assumption of these

responsibilities by state personnel. Other problems were experienced with county welfare departments which were to market the voluntary program to the eligible population when they visited the welfare office. In response to these problems, the state agency took over these duties with little addition in permanent staff resulting in an overwhelming increase in workload. Subsequently, the state gave primary providers the right to do patient recruitment in their offices. This recruitment strategy has raised concerns about the likelihood of favorable selection occurring--i.e. screening out undesirable patients from capitation--which it would seem to foster. The state claims, however, that this situation has not occurred.

New York. Because of its inability to bring in additional providers, the demonstration program in Monroe County has evolved largely into a test of whether a prepaid health plan can reduce the cost of providing care through case management. The program as redesigned during year two was less complex in its risk-sharing and performance targets mainly in order to recruit the one participating prepaid health plan, Rochester Health Network (RHN), which entered into a contract with MediCap --the area's risk-sharing intermediary. It is worth noting that RHN has brought a variety of providers into the system of managed care for Medicaid enrollees, including neighborhood health centers and selected Rochester hospitals. An important issue which has begun to emerge relates to the risk-assuming relationships between MediCap, RHN, and the component providers in RHN. Some

network providers are now seeking to have more of the capitation payment and the financial risk provided directly to them, including the right to pay the claims of specialty services rendered to their enrollees.

Minnesota. Among the most significant design issues accompanying the long-delayed implementation in Hennepin and Dakota counties was the decision to enroll recipients on a randomized basis into the the case management program or traditional Medicaid in Hennepin County (Minneapolis). Thirty-five percent of the eligible population will be enrolled with prepaid health plans (called Medicaid Health Plans or MHPs) while the remainder will remain in fee-for-service. The prepaid program is comprehensive in services covering all Medicaid services with the exception of nursing home costs for persons institutionalized at the time of enrollment. Nine plans responded to an initial request for proposal from the state and seven ultimately received contracts. The participating plans include the state Blue Cross and Blue Shield plan, four existing HMOs, a PPO, and a university-affiliated association of family practitioners and residents. Competition among providers has been limited during the first six months of the program due to the comprehensive nature of required benefits and the newness of the program.

Florida. The Medicaid program has recently developed a revised protocol for its proposed module for the frail elderly. HCFA has granted a "no cost", i.e. no additional funds, extension of

the waivers needed to implement this module and is presently evaluating the protocol. Mt. Sinai Medical Center in Miami remains willing to sponsor the prepaid plan for this population as long as a mutually acceptable capitation rate can be negotiated with the state.

Summary. Year two witnessed few major program design changes for the continuing sites. This suggests that most redesign efforts were related to initial implementation, largely aimed at getting the provider participation necessary to get the programs started. Having addressed program development from a site specific perspective, it is now useful to examine the status of selected program characteristics to see what has been observed and learned about them in year two.

CHAPTER FOUR

STATUS OF SELECTED ISSUES

Critical demonstration program issues are examined across the sites. These issues include:

- | | |
|---------------------------|---------------------------------|
| -Implementation | -Rate Setting |
| -Enrollment | -Management Information Systems |
| -Provider Participation | -Quality Assurance |
| -Payment and Risk-sharing | -Administration and Management |

Implementation

As reported in the case studies and shown in Table 2, the periods of implementation have varied among the programs but have consistently taken longer to complete than expected. These delays are troublesome in time-limited demonstration programs. Program administrators report the tensions between getting started prematurely on the one hand, and jeopardizing program credibility (support) and viability (funds) by being too deliberate on the other hand. Attempting to satisfy conflicting interests of the Federal funding agency and the provider community puts severe countervailing pressures on those responsible for the programs.

The implementation planning period has been marked by enormously time consuming efforts at consensus building and negotiating trade-offs with providers. Importantly, these negotiations can result in program design changes which can fundamentally affect or alter the programs goals. For example, critics of Monterey have suggested that in the face of provider opposition, it negotiated fee-for-service payment rates that

were higher than conventional Medi-cal rates and later efforts to tighten controls were strongly resisted. New Jersey granted a one year waiver of risk to early enrolling providers, to break an impasse and begin operations. In New York, inability of provider groups to form risk-sharing entities limited competitive efforts to existing area HMOs. Missouri expanded its program, which initially was to encompass only prepaid plans, to include an entire set of Medicaid physicians who participate in the Physician Sponsors Program (PSP). This expansion was necessary to defuse the providers' opposition without relinquishing program aims. As discussed below, the trade-off in getting started with existing Medicaid providers or attracting new providers has been another implementation dilemma to be faced by the demonstrations in a number of sites.

Interorganizational and intergovernmental relationships have also played a not-unexpected role in these public programs. Federal, state and local officials have had varying expectations and commitments both to the overall program and selected program features. These concerns have surfaced in the design and the implementation phases. In some cases, disputes have arisen in purely technical areas like rate setting, while in others the concerns have followed more traditional jurisdictional disputes including where the locus of authority should reside to make changes necessary to implement the program. Municipalities operating health service facilities have been reluctant to embrace the programs in several cases because of fear of incurring undue risk because of their perceived uncompetitive positions and the vulnerable

position in which their indigent care responsibilities may place them. The individual case studies should be read to appreciate some of the nuances involved in these areas.

Enrollment

The enrollment process actually includes a number of related procedures:

- Consumer information and education
- Provider selection (or program and provider selection in New Jersey)
- Notification of case manager of enrollment/disenrollment
- Disenrollment and provider changes
- Grievances

Consumer information and education. The public assistance eligibility system and its data files play a critical role in identification and contact of consumers in all sites. Most programs have personnel assigned to local welfare offices to describe the program and selection options available to eligible individuals, including using written and audio-visual materials. Only New Jersey has permitted this function to be carried out by provider-based personnel. Other sites permit some dissemination of provider-developed and program-approved promotional materials to aid in recipient recruitment. While this education includes an orientation to key features of the demonstration, most programs and providers consider this to be only the beginning of the learning

process for enrollees to understand the implications of limited choice and/or managed care.

Provider selection. All of the demonstration programs are mandatory for targeted eligible groups with the exception of New Jersey, which has a voluntary enrollment program. Each demonstration does permit and, in fact, requires selection of the participating plan or provider from whom the individual will receive services. Despite this selection opportunity, a high percentage of individuals fail to exercise it. Surveys in Monroe County, for example, suggest that only about 2 in 3 recipients make their selection themselves. When no selection is made, various forms of automatic assignment methods are used. This can produce other problems as in Missouri where it has been surmised that auto-assigned enrollees have higher out-of-plan use rates than self-assigned persons, while in New York high rates of provider switching among auto-assigned person have led some providers to develop their own schemes of transferring capitation payments among themselves to reconcile accounts.

Provider notification. Once selection of a provider is completed, this information must be communicated on a timely basis to the responsible plan or provider. Delays in this process, which were common, if not pervasive, in the first year of operation, are problematic for the program, confusing for patients, and costly for providers. Reviews conducted in Monterey after termination noted that as much as a \$1.5 million dollars in services may have been provided to individuals not appropri-

ately enrolled with the Initiative, and thus the Initiative was not eligible to receive capitation payments from the state for them. The difficulties initially noted in this area have been solved in most sites although exceptions continue to occur, especially for the more recently implemented programs.

Disenrollment and provider changes. The guarantee of six month eligibility in the demonstrations has greatly simplified the disenrollment problem though disruptions still occur at the end of the guaranteed eligibility period. In states like Florida which have implemented case management programs without this guaranteed, providers reports serious problems are resulting from the high rates of turnover among the eligible population. As already noted, provider changes have presented some problems particularly where auto-assignment has had to be used. Another area of considerable concern has been the disruption of patient-provider relationships for individuals whose providers are unwilling or unqualified to become case managers. This concern has been most commonly noted in Santa Barbara but has arisen elsewhere, especially for the chronically ill and disabled (often SSI-eligible) who have had long-standing provider relationships. This issue has resulted in some program critics and supporters questioning whether case management is appropriate for this class of individuals. In New York, for example, these persons are given the opportunity to opt out of the demonstration.

Grievances. All programs provide grievance systems for

enrollees to register formally concerns, problems, and complaints about any aspect of the program. The number of grievances have been relatively limited considering the potentially disruptive nature of the demonstrations and the relative generosity of the traditional Medicaid programs in which recipients were previously enrolled. While most sites are systematically reviewing the nature of grievances to assess overall trends, findings have not been notable. It does appear that as the availability of personnel to handle grievances increase the number of grievances being filed also increases.

A particularly persistent enrollment problem across the program has been the enrollment of newborn children. Most Medicaid programs permit newborns to become eligible with their mothers until they are subsequently formally added to a case, usually within a month. While this identification of newborns can be problematic from the standpoint of eligibility determination, additional concerns have arisen about which plan they are enrolled with, since they often do not appear as enrollees until they are in the eligibility files. Plans are often unwilling to provide care until they are assured that (1) the newborn is eligible and (2) the mother has elected the plan for the child and the state has begun to issue capitation payments.

Provider Participation.

The critical issue of provider participation can be explored by

looking at three general dimensions: the provider environment, recruitment, and attitudes of participating providers.

Provider Environment. In view of the historically low rates of physician participation in Medicaid and the dissatisfaction expressed by many of those who do participate, it was difficult to anticipate how the provider community would respond to these initiatives. Characteristically, this has varied across the demonstration sites, suggesting the importance of local medical service market conditions. The status of the state Medicaid programs--including fiscal crises with anticipated or actual program and payment reductions--has also been noted in the first year studies as having fostered a climate for change or program reform.

The flexibility of the demonstration programs to involve provider types which traditionally have not been participating in Medicaid has expanded the options available. However, it has been common for some commercial prepayment plans like HMOs to express hesitancy about serving the Medicaid eligible for the first time. For other providers, such as neighborhood health centers, the opportunity to gain experience with prepayment has been welcomed, though with some apprehension. This apprehension is attributed to their having limited financial reserves to absorb adverse consequences and their lack of knowledge about managing risk. For still other large institutional, often teaching, providers with major commitments to care for the indigent and Medicaid populations,

participation was inevitable even if they chose to participate "passively", i.e. by making few changes to respond to program incentives.

Virtually all the demonstrations appear to have benefited from the emerging competitive environment among providers. With hospital occupancies at unprecedented low levels, a growing surplus of physicians, growth in group practices, HMOs, PPOs, etc., providers have shown interest in participation based on the following reasons:

- the opportunity to solidify or expand market share
- the potential to earn higher incomes under the demonstrations from Medicaid patients than fee-for-service, unmanaged care--by improved control over enrollee utilization
- the chance to gain the benefits of more timely and predictable cash flow from prepayment
- fulfill an expected role for public institutions with large Medicaid constituencies

This competitive climate is likely to continue for the duration of the demonstrations and beyond.

Provider Recruitment. During development most programs initially expressed their intent to try to bring into the demonstrations providers who had not previously been major participants with the Medicaid program. This intent was based on both trying to integrate the Medicaid population into "mainstream providers" and also to assure that participating providers possessed the capacity for providing desired quality and continuity of care. Some sites report

progress in this direction although they are more likely to attract traditional Medicaid providers such as public hospitals and health centers. The recruitment of conventional prepayment organizations has been hampered by a number of factors. Program design features and capitation payment arrangements have effectively excluded HMOs in New Jersey; low rates discouraged participation in Florida; and general uncertainty about the viability of serving the intermittently eligible Medicaid population has surfaced in a number of sites. As a result of these factors HMO participation has occurred only in Minnesota (five HMOs), Missouri (a single IPA) and New York (a single network-model HMO).

Competition among providers to enroll eligibles has been limited, somewhat at variance with the avowed aim of these competition demonstrations. The reasons for this appear to be related to such concerns among providers as:

- Is prepayment appropriate for the Medicaid population?
- Do the state or other public agencies have the wherewithal to design, implement and manage effectively such complex programs?
- Are case management responsibilities compatible with the primary care provider's other functions and duties?
- Are risk sharing and opportunities for gain appropriately balanced; i.e. are rates and methods of payment fair and adequate?

Until these questions are answered to provider satisfaction or their concerns suitably allayed, provider recruitment and thus program implementation have been delayed. Consequently, the potential

for providers to begin to compete for more Medicaid recipients can only be fully realized after these problems are substantially resolved.

It is for this reason that fostering provider competition has emerged as a secondary goal to getting the program implemented. A number of sites have had to eschew having a desired spectrum of providers, to negotiate intensively with a few providers to allow the program to gain momentum and credibility. The benefits of this strategy are apparent in the more mature programs which have enabled providers to learn initially that the program is viable, and then to examine their experience to determine if expansion in enrollment is appropriate for them. For example, in Missouri, some providers are now beginning to plan marketing initiatives to expand their enrollments by attracting recipients from their competitors, assuming, as discussed later, capitation rates remain acceptable.

Participating Provider Attitudes. The first year studies described how many providers initially reacted to their program responsibilities. To a certain extent, the near universal difficulties with management information systems, including the absence of such key program elements as prior authorization procedures, dominated their experiences and attitudes. The second year has seen much improvement in this area and provider attitudes seem to have changed accordingly.

Some of this adjustment must be acknowledged as acclimatization to prepayment for those providers with little or no previous

experience with it. This has meant the development of budgeting and other financial systems as well as, in some cases, case management procedures. In addition, making the gatekeeper role an explicit responsibility, in those plans using it, has likewise proven challenging and created a whole new range of issues in inter-provider relationships among primary care physicians, specialists and providers of institutional care. For the hospitals which have chosen to participate as prepaid health plans, varying responses have been noted, with some like the Monroe County area hospitals developing extensive in-house case management systems while others, as in Missouri, have largely continued providing services as usual. A particularly sensitive issue to be addressed when program outcomes are analyzed will be whether such providers should be permitted to continue as participating plans if greater cost savings can be achieved without them.

Providers report that they need time to understand and appreciate the subtleties and complexities of case management. Enrollees need learning time as well especially in regards to the lock-in or limitation on choice aspects of the program. Rationalizing the delivery of services takes efforts providers may not have been previously expending and requires development of formal continuous 24-hour coverage and referral and treatment authorization systems that take time to establish. Plans also have to devise strategies to curb out-of-plan use including deciding whether to pay other providers for unauthorized care. Interestingly, one of the most irritating aspects of the transition has been the requirement that

pseudo- or "dummy" claims be submitted for prepaid care to enable the demonstrations to be evaluated. For some prepayment organizations such as in Minnesota, preparation of these types of "claims" is a new responsibility for which additional staff are required. However, most providers report high levels of satisfaction with the efforts of state and/or Initiative personnel to accommodate their concerns and respond to their problems.

Provider Payment and Risk-Sharing

Among the most difficult and critical features in designing the demonstrations has been the complex configurations in the multi-tiered risk sharing arrangements developed across the programs. These arrangements, in effect, represent the operationalizing of the theoretical assumptions about the kinds of incentives needed to make the demonstrations successful. To illustrate this it is useful to enumerate the levels or tiers around which their payment systems are organized. The tiers include:

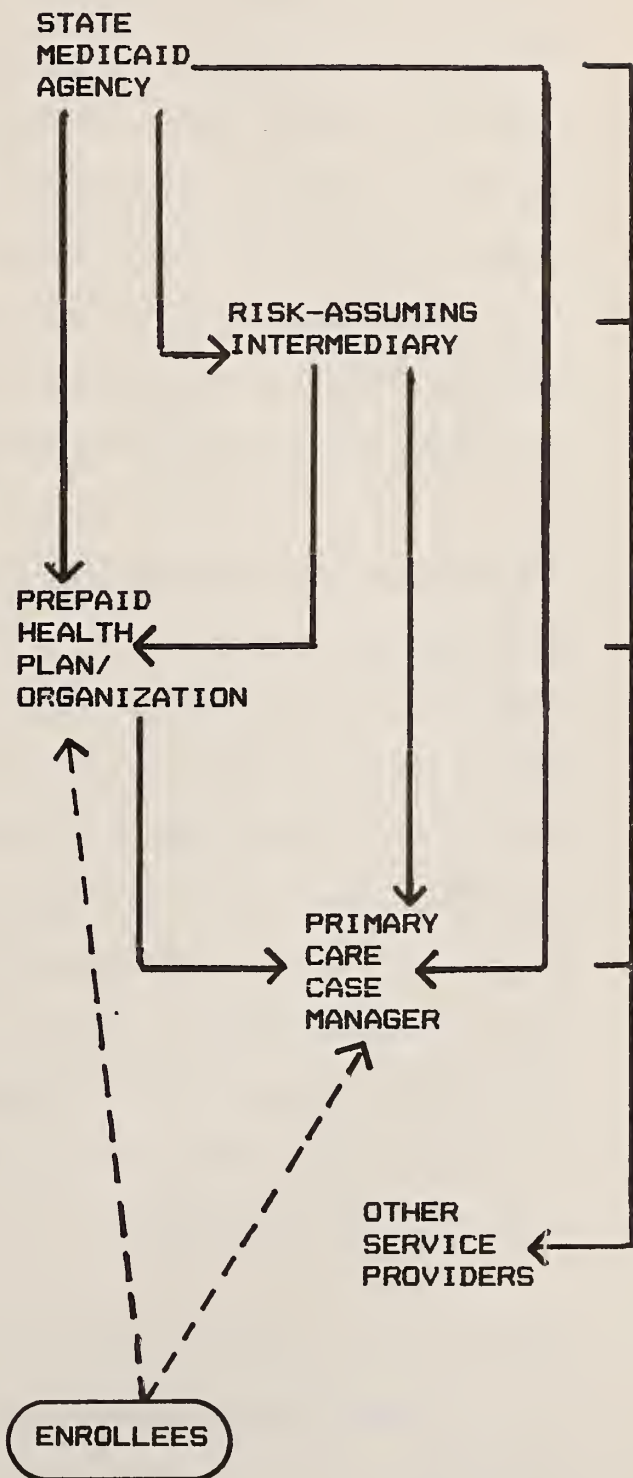
- State Medicaid agency
- Risk-assuming intermediary (where applicable)
- Prepaid Health Plan or Organization (where applicable)
- Primary Care Case Manager (where applicable)
- Other Providers

Table I-4 provides a overview of these structures across the demonstrations illustrating how risk and responsibilities are distributed across the tiers.

STRUCTURAL RELATIONSHIPS IN THE DEMONSTRATION PROGRAMS

TIER

1. **State Medicaid Agency**
may contract with:
 - Risk-assuming intermediary
 - Prepaid health plans or organizations
 - Primary care case managers
2. **Risk-Assuming Intermediary**
may contract with:
 - Prepaid health plans or organizations
 - Primary care case managers
3. **Prepaid Health Plan or Organization**
 - may enroll individuals without assignment to specific case manager
 - may use individual case manager approach with employed or contracted physicians
4. **Primary Care Case Manager**
 - may enroll individuals directly
 - may be engaged by prepaid plan or organizations to perform case management
5. **Other Service Providers**
 - Participation and payment arrangements may be set or negotiated by various tiers in different sites



The **state Medicaid agency** either directly contracts with providers or engages a **risk-assuming intermediary** as in the California and New York programs. In these cases, the state delegates the administration of the program to such an entity and negotiates or sets a capitation rate to enable it to acquire covered services for enrollees. This is customarily a discounted rate (usually 95 per cent) based on the historical fee-for-service equivalent payment. The principal advantage of this system is that the state can guarantee itself savings and the intermediary has an incentive to acquire services for enrollees at the lowest available cost.

The next level--the **prepaid health plan or organization**--may be engaged by the state directly or by the intermediary to assume responsibility for providing covered services. In the state administered programs such as Missouri and Minnesota these plans, are capitated to place them at financial risk. Missouri does permit an exception to this as noted earlier with the Physician Sponsors Program which are not capitated but are paid fee-for-service with a case management fee. In New York where Medicap is a capitated risk-assuming intermediary, the prepaid health plan is a network-model HMO and is also capitated functioning like a secondary intermediary.

Significant variation among the programs is found at the level of the **Primary Care Case Manager (PCCM)**. In some programs case management is an explicit component of the demonstration. In other programs, case management is not a uniform feature, though

prepaid plans may elect to use it as a cost and utilization control technique. In Santa Barbara, the intermediary requires participating providers to be case managers and pays the PCCMs on a capitated basis for primary care services while in Monterey the method of payment was fee-for-service with a case management fee, similar to the Missouri Physician Sponsored Plan. In Itasca (MN), the county is capitated and the physicians (PCCM) are paid fee-for-service with both the county and the physicians sharing in surpluses or deficits. In the other Missouri provider arrangements, and in Hennepin and Dakota programs, the prepaid plans--IPAs, HMOs, neighborhood health centers, hospitals, may (1) elect not to have individually responsible case managers; (2) contract with and capitate PCCMs; or, (3) when the PCCM is an employee, pay a salary. In New York and New Jersey participating providers are expected to adopt the case management approach. These variations in commitment to and employment of the case management concept typify differing assumptions about its expected usefulness in containing costs and improving access.

The final level or tier relates to payment methods or risk sharing for **non-primary care providers** including inpatient care, medical specialists, or non-physician providers. The demonstrations are experimenting with a number of arrangements, ranging from separating this entirely from the primary care payment systems to putting the prepaid plan or PCCM at full risk for all care. It is at this level that the treatment and referral authorization systems become highly important and are closely linked with how financial risk for non-primary care services

is apportioned among the various tiers. To appreciate the nature of these arrangements the individual case studies must be read in detail.

At all of these levels variations can be found reflecting the exploratory and adaptive nature of the risk-sharing process. The variations may be attributed to the assumptions of program developers about the effectiveness of various risk-sharing arrangements. Further they suggest that some programs attempt to be highly explicit about how participating organizations and individuals are to achieve cost savings, while others leave these decisions to the managerial discretion of the plans and providers.

Rate Setting

Equally complex and perhaps more controversial, are the rate setting methods employed across the demonstrations. While this issue was still emerging during the first year case studies, it has now arrived at center stage, especially for the mature programs assessing the long-term possibilities of case management. Some program managers and providers assert rate setting will be the single-most important issue in determining program viability.

Most demonstrations began operations with the goal of outperforming--having costs lower than--the existing fee-for-service equivalent costs

for eligible care, generally on the order of five percent. Relying on consultants and other resources, the states arrived at actuarially determined costs of covered care for various rating categories with some sites using as few as two categories--AFDC adults and AFDC children-- while others use more than seventy, as in Minnesota. These rates were then trended forward, adjusted for geographic differences, and deductions were made for various re-insurance or stop-loss arrangements before finally distributing them to the appropriate program funds for provider disbursement. Some programs such as Missouri have established risk pools for special groups such newborns with major medical problems and have funded them with mandatory deductions from the capitation rates of all plans.

Even assuming a stable base, numerous complexities soon began to surface which took on considerable importance given the tenuous nature of relationships with skeptical providers. Questions about the composition, homogeneity, and number of categories emerged. Trending factors were challenged. The use of local recipient experience rather than state-wide experience was challenged, especially if the number of local eligibles was small. Documentation to support the methodologies was also inadequate, inconsistent or absent. The deductions made for funding reinsurance and stop-loss coverage as well as the computation formulae used have also been disputed in some demonstrations. Delays in getting rates approved at the state or federal level occurred.

A more confounding problem arose when it became apparent that because of other program reforms and larger scale changes in health services, the fee-for-service base was not stable and was evidently declining in a number of sites. Thus, when second year rates were computed some were found to be lower than first year rates, and by substantial amounts in some areas such as New Jersey. Some observers contend that these pressures are just what is needed to compel case managers to manage even more effectively to justify the program's existence, while others are concerned that it may prevent the demonstrations from being able to test adequately the strategies being implemented. In either case, this issue has the potential to inhibit severely physician recruitment and to destabilize provider relations and participation. Consequently, intensive discussions and negotiations are underway in a number of sites to address this problem. Within the evaluation of the demonstrations, the rate setting methodologies and processes are being extensively reviewed.

Management Information Systems

The severe management information system problems of the first year are being solved at most of the sites. In some cases this has meant refinement and redesign, establishing supplemental systems or replacing contractors which failed to produce usable systems on a timely basis. Despite this progress, problems are still apparent and they are exacerbated by growing provider interest

in more sophisticated systems which will enhance their ability to perform their responsibilities in the demonstration programs.

It is important to note that while having an MIS is not an assurance of an effective program, its absence has profound consequences in such areas as:

- program operation and assessment
- eligibility and enrollment linkages
- provider participation and payment
- financial monitoring
- utilization review and management
- quality assurance

In addition to having system components to support each of these areas, the coordination and report generation from them must be precise and timely enough to facilitate such activities as prior authorization of specialty services or pre-admission certification, which some plans and case managers are implementing.

The interrelationship between incentives and provider behavior becomes apparent when looking at such areas as utilization monitoring. Where plans and case managers are at financial risk for specialty care, they wish to be positioned to be aware of and, perhaps deny, unauthorized out-of-plan care. When such problems appear extensive or persistent, the case manager may then implement more stringent authorization measures to solve this problem. In Missouri, plans have had to decide whether to reimburse other providers for unauthorized out-of-plan use. In some cases these

other providers may be competing prepaid health plans who are well aware of the demonstration program and its lock-in provisions for enrollees. When MIS reports are unavailable or unusable, it is not possible to monitor care closely. For example, the reports of specialty use in one site provided to the case manager list the specialist only by Medicaid provider number rather than by name, thus making it difficult for the case manager to address and resolve unauthorized use problems.

Quality Assurance

The second year of operations has witnessed increased attention to quality assurance as well as utilization review in the demonstrations. For a program using prepayment and limitations on choice of provider with an overarching goal of cost containment, concern about under-utilization is generally regarded as the principal quality of care concern. Stated differently, the service use to be reduced by the demonstration programs is intended to be only "unnecessary care." Because of this focus, much of what has been cited as quality assurance activities are largely utilization review issues.

However, some more typically quality assurance activities are now occurring at various demonstration sites:

- Employment of clinical personnel at the state or risk-assuming intermediary levels to oversee or conduct quality assurance efforts

- Monitoring of 24 hour availability of the PCCM
- On-site medical record audits
- Operationalizing of quality assurance plans and committees by providers
- Small scale "sentinel event" studies across providers
- Development of clinical management protocols for selected high prevalence conditions

Notwithstanding these examples, the plans uniformly cite quality assurance as an area to which they will devote additional attention and resources in the next year.

Administrative and Managerial Concerns

The final issue which incorporates many elements of those previously presented is program administration or management. These programs have severely tested the developing agencies' abilities to take them from conceptualization to full implementation in highly compressed time periods. Since most Medicaid agencies have neither the organizational slack nor many of the requisite technical skills in-house, reliance on outside consultants has been extensive. At best this added another layer of administrative complexity and, at worst, it has provided the basis for serious conflict, especially when consultant non-performance has become an issue.

A core group of committed staff has proven critical in certain sites, while others have experienced substantial turnover but have

still been successful, suggesting that other factors play a role beyond permanency of personnel. The tensions between delegating and centralizing functions, as noted in New Jersey and elsewhere, have also been played out differently, assuming that some minimum, adequate number of personnel are engaged in the key program operations. Provider perceptions are also important. Providers have reported how disconcerting it can be to have to deal with a stream of unfamiliar and continually changing personnel.

The evidence on the advantages and disadvantages of the risk-assuming intermediary tier versus direct contracting between the state and prepaid health plans and providers is mixed and inconclusive. The risk-assuming intermediary can link and tailor a program to a local market, but it also adds another party to the complex round of negotiations required to get a demonstration program started. In addition, as some critics suggest for Monterey, the strained state-Initiative relationship was a contributing factor to the ultimate demise of the program. For New York, some have questioned the role of MediCap when only a single provider network is participating, thus seeming to render MediCap's position duplicative, at least until other plans are recruited.

CHAPTER FIVE

KEY ISSUES EMERGING IN YEAR THREE

This section describes a number of issues which are emerging as critical for the demonstration programs. The implications and potential consequences of these issues are discussed.

As previously noted, the continuing programs remain at various points of development and maturation as many enter what is expected to be the final year for them, unless extensions are granted. A number of important developments are expected:

- Transition to permanent status for certain programs
- Continued transformations in local health service markets
- Increased evidence of competition among providers for enrollees
- Rate setting to become more contentious
- Quality assurance programs to become more prevalent and stringent
- Case management to be better understood by providers and enrollees
- Appropriateness of case management to be challenged for selected eligibles

These issues are now briefly described.

Transition. Santa Barbara, Missouri, and New Jersey have requested 1915(b) waivers from HCFA to continue their case management programs when the demonstration funding expires in 1986. Such waivers are required because of a number program features represent exceptions to conventional Medicaid program requirements and thus must be specifically exempted via the waiver process. The

Santa Barbara and Missouri programs are likely to be approved and few significant changes are expected, since both report that their own cost analyses suggest positive financial results, a requirement for granting the waiver. As discussed previously, rate setting will be an issue of major importance in both of the programs; in California because of the shrinking fee-for-service base and the administrative cost dispute with the state; and in Missouri because of the program's expressed interest in going to provider-specific capitation rates. More competition is expected among providers if rate setting is perceived as satisfactory. The New Jersey waiver request is currently under review.

Transformations in local health service markets. As hospital occupancies continue to decline, alternative delivery system enrollment continues to grow and competition grows more fierce among providers, the capitated demonstrations will receive at least indirect support from these larger market forces, especially as fee-for-service payment becomes the exception rather than the rule, as it appears to have in such places as the Minneapolis area. To a limited extent, the demonstrations have stimulated interest in prepayment among providers, like the neighborhood health centers in Missouri, and given them much needed experience with it. Despite these changes, it is not yet clear if program designs or recruitment strategies will succeed in bringing more previously non-Medicaid providers into participation, or simply will convert traditional providers to prepayment.

Competition among providers for enrollees. Even if few additional providers enter the demonstrations or their successor programs, it is expected that where the program proves creditable and feasible, economies of scale will be pursued. It will be of interest to see if--given the nature of the mandatory basic service coverage of the programs--some providers attempt to add optional services to attract enrollees. Another alternative would be more intensive media-related publicity efforts which have not proven particularly effective in affecting initial plan/provider choice. This competition also presumes the maintenance of capitation and other rates which are acceptable.

Rate setting conflicts. In order to assure provider participation the programs are required to pay rates which are perceived by providers as adequate. One of the principal lessons of the failure of Florida's demonstration was its inability to recruit prepaid health plans by offering rates discounted from what were already among the lowest Medicaid fee-for-service rates in the country. For program managers and providers, the negotiation and retention of adequate rates is likely to be a source of severe conflict, especially if the program has proven to be feasible and profitable. This issue has significant political and equity overtones, as well as technical ones, which suggest it will not find easy solutions despite the clear aim of cost containment.

Quality assurance. For programs that have demonstrated that they can be implemented and cost savings can be achieved,

the next questions which inevitably arise are how were the savings attained and what may have been given up. This issue is likely to intensify interest in finding out if the reductions in service cost, use, or substitution effects of less expensive for more expensive care, have had adverse health consequences. Recognizing the difficulty in arriving at definitive findings in assessing quality, the principal effects of this increased concern will be development of more comprehensive provider based quality assurance programs.

Understanding case management. Despite assertions by many primary care providers that they have always been "case managers," the embodiments of case management found in many of the demonstration programs has taken time to learn and understand--both for providers and enrollees. This is important to note for two reasons: (1) learning effects are more likely to be apparent in provider and Medicaid recipient behavior as more as time passes; and (2) "gaming" of the system is likely to increase as sophistication grows. This latter point may apply both to the recipient, for example, who realizes that the emergency room is unlikely to turn away an insistent but unauthorized patient, and to the provider who may try to encourage high-risk individuals to enroll elsewhere. The key issue is that case management, like prepayment enrollment, provides an acculturation experience which will take time to absorb.

Limitations on the appropriateness of case management.

Some evidence has already emerged that primary care case

management may be inappropriate for certain individuals with long-standing provider relationships for chronic conditions. To the extent these providers are not candidates to become primary care case managers, disruptions and discontinuity may result. These patients and others with pre-existing conditions also present problems of adverse selection for providers with whom they do enroll, sometimes requiring setting up complicated risk pools for such circumstances. It is likely that other programs, particularly those which cover the disabled populations as well as AFDC and SSI eligibles, will exempt these individuals from the conventional case management program--as has been done in Monroe County--or will devise some alternative program for them.

CONCLUSION

Significant progress occurred in most of the demonstration sites during the periods covered in the second round case studies. The problems addressed by most programs were ones of implementation and operation rather than of design and consensus building which marked the first year. Much more has been learned about the feasibility and difficulty of making these programs work and in two cases it has become apparent that the programs will continue after the demonstration has been concluded. However, the answers to many other questions are inconclusive, and the long term fates of the other programs and of the cost containment strategies embodied in the demonstrations are still unknown.

APPENDIX

Adapted from Appendix to "Summary of Case Studies of Medicaid Competition Demonstration Projects," authored by Pamela Haynes. American Enterprise Institute, Washington, D.C., 1984. Report prepared under HCFA Contract No. 500-83-0050.

SANTA BARBARA COUNTY HEALTH INITIATIVE

STRUCTURE: -Primary care case management model with prepaid capitation set 95% of fee-for-service cost. Independent county authority administers program, contracts with case managers, shares risks with providers.

STATUS/ -Operational since September 1983. Planning had been
DEVELOPMENT: underway prior to demonstration funding becoming available.

ELIGIBILITY:-Mandatory for Medi-Cal eligibles, including AFDC and SSI, in Santa Barbara County.

-Medically needy handled under different program.

-Target enrollment: 20,000 - 25,000.

LEGISLATION/-Authority created by state legislation.
WAIVERS:

-State financial reserve requirements for prepaid plans waived.

-HCFA Section 1115(A)(1) waivers for variation in amount, duration and scope of benefits, variation in state wide program, restricted freedom of choice of provider, flexibility in provider reimbursement arrangements, flexibility in eligibility redetermination, flexibility in utilization review. Section 1115(A)(2) waivers related to HMO enrollees.

PROVIDER -All Medi-Cal providers may contract with Initiative.
CHARACTER-
ISTICS: -Case managers may include solo and group practitioners, county health service clinics, and hospitals

PAYMENT -Initiative makes capitated payments to primary care
SYSTEMS: case managers to cover primary care and maintains accounts to pay for referral care.

PROVIDER -Case manager at risk for 20% of primary care portion

INCENTIVES: of capitation.

-Case managers will collect 20% if they keep service costs below capitation. Can share surplus with Initiative.

SERVICES COVERED: -All Medi-Cal services except dental care.

BENEFICIARY: -Minimal since participation is mandatory.
INCENTIVES

-May choose case manager; have benefits of access to one physician and continuity of care, and option of changing case manager.

ADMINISTRATIVE FUNCTIONS: -Eligibility determined by county social service agency.

-Initiative acts as broker and is responsible for administration, including utilization review, quality assurance, enrollment, grievance procedures.

-Initiative contracts with fiscal agent for claims processing and reporting function.

MONTEREY COUNTY HEALTH INITIATIVE

STRUCTURE: -A primary care network where patients chose primary care physicians or county hospital to be case manager. Independent county authority was at risk for all Medi-Cal services. Authority received capitation from state equal to 95% of fee-for-service cost except 100% for long-term care.

STATUS/ -Began operations in June 1983 and terminated operations
DEVELOPMENT: in March 1985 (formally dissolved in June 1985).

ELIGIBILITY:-Mandatory for Medi-Cal eligibles, including AFDC and SSI, in Monterey County.

-Medically need handled under different program.

-Target enrollment: 28,000.

LEGISLATION/-Authority created by state legislation.
WAIVERS:

-State financial reserve requirements for prepaid plans waived.

-HCFA Section 1115(A)(1) waivers for variation in amount, duration and scope of benefits, variation in statewide program, restricted freedom of choice of provider, flexibility in provider reimbursement arrangements, flexibility in eligibility redetermination. Section 1115(A)(2) waivers related to HMO enrollment rules.

PROVIDER -Primary care and specialist physicians contracted
CHARACTER- with Authority.
ISTICS:

-County-run hospital, Natividad Medical Center, was largest case manager.

PAYMENT -Physician case managers paid on fee-for-service basis
SYSTEMS: plus monthly case management fee of \$3 (later \$1.50).

-Natividad paid 100% of charges without management fee.

-Other hospitals paid 92% of charges with bonus possible.

-Other providers paid fee-for-service rates.

NOTE: Due to financial difficulties payment systems were modified during the demonstration.

PROVIDER INCENTIVES: -Physician case managers not at any financial risk.

-Hospital payment rates (initially) were above Medi-Cal reimbursement levels.

SERVICES COVERED: -All Medi-Cal services except dental care.

BENEFICIARY INCENTIVES: -Minimal since participation was mandatory.

-Could choose case manager; had benefits of access to one physician and continuity of care, and option of changing case manager.

ADMINISTRATIVE FUNCTIONS: -Eligibility determined by county social service agency.

-Authority acted as broker and is responsible for administration, including utilization review, quality assurance, enrollment, grievance procedures.

-Authority contracted with fiscal agent for claims processing and reporting function.

FLORIDA ALTERNATIVE HEALTH PLAN FOR THE FRAIL ELDERLY

STRUCTURE: -Hospital-based provider to offer services to frail elderly population in a designated area under contract to state agency.

STATUS/ -Still in planning and negotiation stage with
DEVELOPMENT: implementation anticipated in Fall 1986.

ELIGIBILITY:-Medicaid eligibles who have applied for or been found eligible for nursing home assistance.

-Voluntary enrollment.

-Enrollment target of at least 400 persons.

LEGISLATION/-HCFA 1115(A)(1) waiver for variation in amount, duration and scope of benefits and variation in
WAIVERS: statewide program. Section 1115(A)(2) waivers related to HMO enrollment rules.

PROVIDER -Mt. Sinai Medical Center, Miami Beach, expected to
CHARACTER- be demonstration provider.
ISTICS:

-Medical Center has good record of care for frail elderly, convenient location, interest in other elderly demonstration programs, good financial status.

-Provider must have ability to assume full risk and provide services, and have a data system in place.

PAYMENT -Prepaid based on historical fee-for-service rates.
SYSTEMS: Will not exceed 95% of fee-for-service. Rates may be renegotiated annually.

-Rate protocols are still under review by HCFA.

PROVIDER -Potential for increasing market share.

INCENTIVES: -Can retain surplus if cost are less than capitation.

SERVICES COVERED: -Comprehensive range of services, including health and community-based care, adult day care, case management, respite care, counseling, escort care, health support and personal care, home management and homemaker services.

BENEFICIARY: -To be determined by provider; may include open enrollment periods and additional benefits.

ADMINISTRATIVE FUNCTIONS: -Department of Health and Rehabilitative Services (DHRS) will determine eligibility.

-Provider responsible for case management, controlling out-of-plan use, marketing and enrollment.

-Fiscal agent will process claims.

MINNESOTA PREPAID MEDICAID COMPETITION DEMONSTRATION

STRUCTURE:—Medicaid population being enrolled on a mandatory basis in a variety of prepaid plans—including HMOs and other organizations --under capitated system. Enrollees will choose among providers in 3 counties only—one rural, one urban, one suburban.

STATUS/ —Implemented in Itasca County in August 1985, and
DEVELOPMENT: Hennepin and Dakota in December 1985.

- Extensive planning process involving 45-member advisory committee lasted more than three years.
 - Itasca County (rural) implemented without competing plans with capitation payments made directly to county.
 - In Hennepin County, 35% of the eligible population are being assigned to demonstration on a random basis and remainder are being served by traditional Medicaid system.
-

ELIGIBILITY:—Mandatory for almost all Medicaid eligibles in participating counties, including AFDC, SSI and medically needy. Random assignment in Hennepin.

- Three small groups excluded: "six-month spend downs," residents in state institutions, people who receive personal care attendant service.
-

LEGISLATION/—State legislation passed.
WAIVERS:

- HCFA Section 1115(A)(1) waivers for variation in amount, duration and scope of benefits, variation in statewide program, restricted freedom of choice, flexibility in provider reimbursement arrangements, release of patient information to broker. Section 1115(A)(2) waivers related to HMO enrollment rules.
-

PROVIDER —HMOs, physician groups, and other health care organiz-
CHARACTER ations can contract with state to serve as plans.
ISTICS:

- Providers accepting AFDC or blind eligibles must also

take aged and/or disabled.

- Must meet state requirements for array of services, capacity to accept new enrollees, subcontracting arrangement with providers, financial viability, quality assurance, utilization review and grievance procedures.

**PAYMENT
SYSTEMS:**

- Capitation set at 90% of fee-for-service for AFDC, 95% of fee-for-service for aged, blind, and disabled. Rates based on age, sex, institutional setting, eligibility category, and Medicare status.
- Capitation does not cover long-term nursing home costs. It includes only the first 90 days of care within fiscal year for enrollees who entered institutions during enrollment in plan, and 20% of costs thereafter until end of fiscal year.
- Risk limitations for nursing home and hospital costs, optional reinsurance plan, 2-year stop-loss cap.

**PROVIDER
INCENTIVES:**

- May keep surplus if costs of care kept below capitation rate.
- Desire to keep or expand enrollees in tight market.
- Capitation creates incentives to keep enrollees out of nursing home, but not to de-institutionalize long-term nursing home patients.

**SERVICES
COVERED:**

- All Medicaid services, except nursing home care for enrollees classified as institutionalized.

**BENEFICIARY
INCENTIVES:**

- Minimal since participation is mandatory.
- Provider may offer benefits in addition to Medicaid service package.
- Will have advantages of relationships with one provider and improved continuity of care.

**ADMINISTRATIVE
FUNCTIONS:**

- In Hennepin and Dakota, plans are responsible for contract negotiation with providers, data systems,

quality assurance, utilization review, grievance procedures. County assumes these functions in Itasca.

- State is responsible for contracting with and monitoring plans, determining rates, processing claims, providing technical assistance to counties.
- Counties responsible for determining eligibility, over-seeing enrollee plan selection.
- Consulting group, chosen by competitive bidding, assisted in planning and development.

MISSOURI MANAGED HEALTH CARE PROJECT

STRUCTURE: -Medicaid recipients given a choice of enrolling in prepaid health plan (PHP) or with a primary care physician. Operational in Jackson County (Kansas City).

STATUS/ DEVELOPMENT: -State Department of Social Services (DSS) assembled project team to implement demonstration over a 17-month period. Became operational in November 1983.

ELIGIBILITY: -Mandatory for approximately 25,000 AFDC recipients in Jackson County.

LEGISLATION/ WAIVERS: -State legislation authorized DSS to offer PHPs to Medicaid recipients.

-HCFA Section 1115(A)(1) waivers for variation in amount duration and scope of benefits, variation in statewide program, restricted freedom of choice of provider, flexibility in provider reimbursement arrangements, flexibility in eligibility redetermination. Section 1115(A)(2) waivers related to HMO enrollment rules.

PROVIDER CHARACTERISTICS: -Five PHPs are participating including 2 hospitals, 2 neighborhood health centers and 1 federally qualified HMO (IPA model).

-Approximately 55 primary care physicians are participating in the Physician Sponsor Program (PSP) and agree to function as "primary care gatekeepers," i.e., provide basic medical care, make referrals to specialists, and manage all hospitalizations

PAYMENT SYSTEMS: -PHPs are paid a monthly capitation rate set at approximately 90% of Medicaid fee-for-service. Two age classes established: AFDC adult and AFDC child.

-PHPs required to participate in reinsurance pool to limit risks including adverse selection. Other risk

limitations are available.

-PSP physicians receive \$1.50 case management fee per month per enrollee, in addition to fee-for-service payment.

**PROVIDER
INCENTIVES:**

-PHPs desire to maintain or expand patient share.
-PHPs may keep surplus if costs are below capitation.
-PSP physicians have opportunity to manage Medicaid care; receive management fee.

**SERVICES
COVERED:**

-PHPs offer most Medicaid benefits except drugs, emergency transportation, dental, adult day health nursing home care.
-Under PSP, recipients entitled to usual Medicaid services.

**BENEFICIARY:
INCENTIVES**

-PHPs may offer additional benefits beyond Medicaid package.
-PHPs eliminate all cost-sharing and benefit limitations and guarantee recipients 6 month eligibility.
-Physician sponsors expected to improve continuity of care.

**ADMINISTRATIVE
FUNCTIONS:**

-Project team conducted negotiations with providers and developed capitation rates.
-Medicaid Management Information System maintains enrollment and claims data and makes provider payments.
-State conducts utilization review and monitors PHP grievance procedures.

NEW JERSEY MEDICAID PERSONAL PHYSICIAN PLAN

STRUCTURE: -Voluntary, capitated, primary care case management system where eligibles choose case manager for initial 6-month period. Statewide program being phased in by county areas.

STATUS/ -Phase I enrollment began July 1983 to predom-
DEVELOPMENT:inantly rural counties.

-Phase II enrollment in August 1984 to several urban counties.

ELIGIBILITY-Voluntary for all non-institutionalized Medicaid eligibles, including AFDC, SSI Refugees, Old Age Assistance, Division of Youth and Family Services.

-Target enrollment: Not specified.

LEGISLATION/-No state legislation or regulatory changes required.
WAIVERS:

-HCFA 1115(A)(1) waivers for variation in amount, duration and scope of benefits, variation in statewide program, restricted freedom of choice of provider, flexibility in provider reimbursement arrangements, flexibility in eligibility redetermination, release of patient information to broker. Section 1115(A)(2) waivers related to HMO enrollment rules.

PROVIDER -State licensed, Medicaid-certified primary care providers
CHARACTER- can contract with state to be case managers.
ISTICS:

-Includes family and general practitioners, internists, and pediatricians, in solo practice, groups, clinics, HMOs.

PAYMENT -Capitation rates 95% of projected fee-for-service costs
SYSTEMS: trended from 1981-82 claims and eligibility data.

-Capitation rates based on age, sex, county of residence category of eligibility.

-Capitation divided into primary care, referral service, inpatient care, reinsurance components.

- State maintains component accounts for each provider and reconciles periodically.

PROVIDER INCENTIVES: -At risk for total amount of primary care, and portion of referral services.

- May receive \$200 lump sum for successful treatment of patient outside of hospital, if he/she might have required admission otherwise.
- May keep surplus in capitation accounts, but may have to pay state balance of deficit up to maximum provider liability level.
- 12-month waiver of risk for case managers who sign up early.

SERVICES COVERED: -All Medicaid services except long-term care, dental services, emergency transportation.

BENEFICIARY INCENTIVES: -Voluntary enrollment.

- Continuity of care, preventive services, on-going relationship with one provider, six-month eligibility guarantee.

ADMINISTRATIVE FUNCTIONS: -State Medicaid agency initially contracted out several functions to other organizations but has now assumed most of these functions itself.

- State is responsible for physician marketing and contracting, capitation determination, grievance procedures, quality assurance, utilization review.
- Providers are permitted to market to and to enroll eligible persons directly in their offices.
- State fiscal agent maintains eligibility files, pays capitation and processes claims.

NEW YORK (MONROE COUNTY) MEDICAP PLAN

STRUCTURE: -Prepaid capitated program in which enrollees select from providers who are affiliated with a prepaid health plan. MediCap, Inc. serves as broker, fiscal intermediary, and administrative agent.

STATUS/ DEVELOPMENT: -The initial health plan, Rochester Health Network (RHN), began participation in June 1985 and remains the only participating plan. RHN has 12 participating providers including physician groups, health centers, and hospitals. Negotiations are continuing to engage other plans.

ELIGIBILITY: -Mandatory for all Medicaid eligibles, except those over one year of affiliation with a non-participating provider.

-Eligibles being phased in on annual basis beginning with AFDC and Home Relief (HR) in first year.

-Initial enrollment target: approximately 47,000 AFDC and HR eligibles.

LEGISLATION/ -State enabling legislation for all but long term care passed June 30, 1984.

WAIVERS:

-HCFA Section 1115(A)(1) waivers for variation in amount, duration and scope of benefits, variation in statewide program, restricted freedom of choice, flexibility in provider reimbursement arrangements.
1115(A)(2) waivers related to HMO enrollment rules.

PROVIDER CHARACTERISTICS: -Only HMOs and IPAs can serve as MediCap providers.

-Individual providers must affiliate with HMOs to spread risk.

-Standards to include financial status, acceptance of Medicaid, internal utilization review, admitting privileges, state licenses.

PAYMENT SYSTEMS: -Prepayment plans are paid monthly capitation amount of 94% of fee-for-service equivalent by MediCap and are at risk for providing all services.

-Community-based target rates were developed based on eligibility category, age, and sex. Options available to providers include stop loss and contingency funds or full risk. Providers may elect to pay specialists and hospitals directly or have MediCap perform this function.

PROVIDER INCENTIVES: -Competition for patients in a tight health care market.
-Can retain surplus if costs are below capitation rate.

SERVICES COVERED: -Standard Medicaid services including prescription drugs.
-Dental and long-term care initially excluded.

BENEFICIARY INCENTIVES: -Minimal since participation is mandatory.
-Continuity of care, choice of participating provider, option of changing case manager.

ADMINISTRATIVE FUNCTIONS: -Eligibility determined by county social service agency.
-MediCap responsible for marketing, provider enrollment, managing accounts, quality assurance, grievance procedures, payment to providers, and management information services.

Evaluation of Medicaid Competition Demonstrations

Volume II

The Santa Barbara Health Initiative

by

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Preface

In September 1983, the Office of Research and Demonstrations in the Health Care Financing Administration awarded a contract to a consortium, headed by the Research Triangle Institute (RTI), to evaluate Medicaid competition demonstrations in six states: California, Florida, Minnesota, Missouri, New Jersey, and New York. An important aspect of the evaluation is conducting a series of case studies on each of the participating demonstrations that trace their development and implementation. These case studies are being carried out by the American Enterprise Institute's Center for Health Policy Research, and Lewin and Associates, Inc. The case studies for each of the sites are to be performed on four occasions at annual intervals, although the activity in the individual sites may suggest alternative schedules.

This report is the second case study on the Santa Barbara County Special Health Care Authority. It was prepared based on a site visit conducted during March 1985. The first case study was prepared based on a site visit made in December 1983.

The author is appreciative of the time and effort of the Santa Barbara County Special Health Care Authority staff, in particular, Steven Krivit, Director of Government Relations. I am also grateful to Jack A. Meyer, Director of the Center for Health Policy Research at the American Enterprise Institute for his comments and suggestions.

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Chapter One
Overview of the Demonstration

The Santa Barbara Health Authority has been operating the state's Medi-Cal program in Santa Barbara County since September 1983. The Authority has contracted with the state to arrange for the provision of Medi-Cal services to the county's eligible population. In turn, the Authority has been empowered by state enabling legislation to negotiate contracts with providers and administer the Initiative under the direction of its 11-member Board of Directors. A 35-member staff, in addition to the fiscal agent's staff, carries out daily program operations.

All persons who are eligible for Medi-Cal in the county receive their care from physicians who have negotiated contracts with the Authority. All Medi-Cal benefits, except dental care, are provided under the Initiative. Currently, the average monthly enrollment is 20,800 beneficiaries.

The purpose of the demonstration is to test whether the Authority's innovations in administering the Medi-Cal program are effective controlling the costs of providing care by eliminating unnecessary services, assuring beneficiaries a point of access to health care services, and maintaining quality care. The innovations are perceived as alternatives to the fee-for-service system which has offered little incentive to control the

rate of increase in health care costs which the state believes is unsustainable.

The demonstration will test whether changed financial incentives can control health care costs and whether cost savings that do accrue are attributed to reduced hospital admissions, shorter lengths of stay, elimination of unnecessary use of emergency rooms or elimination of necessary care. The demonstration will then determine whether the costs savings can be attributed to capitation, case management, utilization review, provider risk under capitation payments, or a combination of these features. Substitution effects such as the use of ambulatory care for hospital care and primary care for specialty care as well as changes in referral patterns among specialists and among hospitals will be shown. The effect of changes in the use of health care services on the quality of care will also be examined.

At the time of the site visit in March 1985, the program had completed one and a half years of operation. The Authority concludes that in the first year it succeeded in administering the Medi-Cal program at a lower cost than the state would have incurred under the fee-for service system. Its first operating year ended with a surplus of approximately \$900,000 (\$520,000 of this allocated to the risk reserve). This amount is in addition to the funds in physician trust accounts which totaled \$1 million.

In March 1985, the Authority projected a deficit of approximately \$650,000 for the second fiscal year based on the rates

that the state offered. Subtracting interest income from cash on hand, the deficit amounted to \$250,000. One reason for the projected deficit was that the Authority is paid 95 percent of the amount the state would have otherwise spent in Santa Barbara county under the fee-for-service system. Statewide cost control efforts such as hospital contracting whereby the state negotiates reimbursement rates with certain hospitals, and limits on provider reimbursement would have limited the growth of expenditures had the traditional fee-for-service Medi-Cal program been in effect in Santa Barbara. Hence, the fee-for-service base from which capitation payments are calculated has decreased in relative terms. Also, there are about 2,000 fewer eligibles per month than when the program first started (for which there is no clear explanation). This decrease in the number of eligibles increases administrative costs per eligible.

On March 18, 1985, the Board of Directors of the Authority considered whether to vote on terminating its contract with the state, due to the projected deficit, based on the rates offered by the state. After asking the Board to postpone its vote, the state shortly thereafter offered \$354,000 to offset a portion of the projected shortfall. The Board accepted the state's offer and signed a contract including rates for the second operating year.

Chapter Two

Overview of the County and State Medi-Cal Program

Overview of the County

A. Provider Characteristics

The county's health resources are not geographically distributed in proportion to where Medi-Cal recipients reside. Approximately 60 percent of all Medi-Cal recipients live in the northern Santa Maria Valley and central county areas, whereas the majority of physicians, hospitals, and skilled nursing facilities are in the southern part of the county around Santa Barbara. In the northern part of the county, Santa Maria has 846 persons per physician, whereas Santa Barbara has 343 persons per physician.

The health care market in Santa Barbara County is rapidly changing. The following changes are evident:

- o continuing decline in hospital occupancy
- o growth in the number of preferred provider organizations
- o increase in the number of skilled nursing facility and intermediate care facility beds

Hospital Occupancy Hospital occupancy rates continued to decline in the second quarter of 1984. Whereas in the second quarter of 1982 the occupancy rates ranged from 30 percent to 85.7 percent, in the second quarter of 1984, occupancy rates ranged from 29.8 percent to 68.5 percent.

<u>Hospital</u>	<u>Occupancy Rate</u> <u>2nd Qtr. 1984</u>	<u>Occupancy Rate</u> <u>2nd Qtr. 1983</u>	<u>Occupancy Rate</u> <u>2nd Qtr. 1982</u>
Cottage	54.7	62.7	72.1
Pinecrest	42.2	50.5	67.3
Goleta Valley	33.0	42.1	53.7
Lompoc District	61.6	63.2	76.0
Marian	62.4	73.0	80.1
St. Francis	43.3	50.9	55.3
Valley Community	68.5	61.7	85.7
St. Ynez	29.8	43.4	30.0

(Source: Ventura County and Santa Barbara County Health Systems Agency)

The decline in hospital occupancy in Santa Barbara reflects the statewide trend. In 1982 average hospital occupancy rates were 61.1 percent and in 1983 dropped to 59.3 percent. In 1984 they dropped again to 56.6 percent.

Occupancy rates, however, have been in tremendous flux in Santa Barbara County since the 1984 health systems agency data were collected. The implementation of Medicare DRGs, the development of preferred provider organizations (PPOs), and the growth of health maintenance organizations (HMOs) have had an impact on occupancy rates. At the time of the first site visit in December 1983 there was one HMO in the county, one PPO sponsored by Prudential, one PPO being developed by Blue Cross and one PPO sponsored by Blue Shield. Currently, five PPOs and two HMOs are operating in the county. There is no available information on their aggregate or individual market shares.

The development of PPOs and HMOs has segmented the physician community into three groups: those serving the Santa Barbara Medical Foundation Clinic, those associated with the Sansum Clinic and those who are independent physicians. Each group of physicians is affiliated with one or more PPOs or HMOs. The medical foundation clinic has a closed-panel HMO and is aligned with two PPOs and has signed a contract with the Authority to provide specialty care; the Sansum clinic aligned itself with Prudential's Pru-Net PPO and provides specialty services to the Authority; those physicians who participate as case managers in the Initiative are primarily the independent doctors who have also signed contracts with a new PPO, California Preferred Providers, Inc. (CPPI).

The effect of PPOs and HMOs on hospital admitting patterns has been dramatic, at least in the short-term. The director of CPPI said that independent physicians are admitting their patients into Goleta and St. Francis hospitals rather than Cottage Hospital. This change is perceived as a response to physicians at the Sansum and medical foundation clinic admitting patients exclusively to Cottage Hospital.

CPPI, which is cultivating support among independent physicians, hopes to develop a case management model for the private sector with features similar to those in the Santa Barbara Health Initiative. The director of CPPI believes that such a program as planned in the private sector would not be feasible without the experience physicians have had in the

Santa Barbara Health Initiative. Thus, the Initiative has served as a catalyst for activity in the private sector.

Physician Supply Approximately 125 physicians serve as case managers through contracts with the Authority. Over 300 specialist physicians have signed contracts to serve as referral physicians. There has been no net increase in the number of practicing physicians in Santa Barbara County in 1984. It cannot be concluded whether the percentage of physicians serving Medi-Cal patients and the extent of physician participation has increased or decreased. The Authority attributes this uncertainty to the fact that data on provider participation prior to the Initiative includes duplication and is incomplete.

Skilled Nursing Bed Supply The state recently has approved a net increase of 91 skilled nursing facility (SNF) beds, 22 intermediate care facility (ICF) beds and 59 intermediate care facilities for the developmentally disabled (ICF-DD). Two hospitals, Valley Community Hospital and Marian Medical Center, have each received approval to add 63 SNF beds and 23 ICF beds. One hospital, Lompoc District, received approval to upgrade 24 ICF beds to SNF beds. Another hospital, Hillside House, will be converting 59 SNF beds to ICF beds for the developmentally disabled. In addition, Pinecrest hospital's 99 SNF beds were recently certified to be available for Medi-Cal patients.

The state approved the addition of the SNF beds in response to the perceived need in the northern part of the county where the SNF occupancy rate in 1983 was 99 percent. Although it would appear likely that hospitals would have a special need for more SNF beds because of the incentives under Medicare's Diagnosis-Related Groups (DRGs) to discharge patients from the hospital earlier, observers contend that the need for these additional facilities was recognized long before DRGs were implemented. Because of the upgrading of ICF beds to SNF beds, currently there are no licensed ICF beds in the county; the approved ICF beds will not be available until 1987.

B. State Medi-Cal Program Changes

The state's policy for Medicaid reform is to develop competition among providers of Medi-Cal services to render comprehensive services to beneficiaries. Two models being used to carry out this policy are county-organized health systems and enrollment in prepaid health plans.

County-Organized Health Systems The county-organized systems are based on, but are not limited to, the model of the Santa Barbara Health Authority. Currently, San Mateo county is developing such a system and two other counties, San Bernardino and Orange counties, have expressed an interest in developing a comparable system.

Enrollment in Prepaid Health Plans Under the expanded choice program the state is attempting to enroll more Medi-Cal beneficiaries in existing prepaid health plans. The state has

received federal waivers to allow the California Medical Assistance Commission to enroll Medi-Cal beneficiaries in prepaid plans as an alternative to the fee-for-service system in six target areas. Thus far, parts of Los Angeles County, San Diego, and Stanislaus Counties have been chosen as three of the six target areas. Under current state law, and with waivers from federal Medicaid regulations, up to 20 percent of all Medi-Cal recipients can be enrolled in prepaid plans.

Currently, there are 33 prepaid health plans in California, 11 of which have signed contracts with the state to serve Medi-Cal patients. Through the expanded choice provisions some state policymakers would like to increase the number of Medi-Cal beneficiaries who can be enrolled in prepaid plans. One legislative proposal introduced by State Senator Maddy would increase the number of Medi-Cal beneficiaries who could be enrolled in prepaid plans to 60 percent by 1989. In January of 1984, similar legislation was introduced which would have increased the number of beneficiaries who could be enrolled in prepaid plans. These proposals were rejected, in part because legislators did not agree on the timetable for enrolling beneficiaries. Some policymakers are cautious about enrolling too many beneficiaries too soon in prepaid plans, because they perceive that meeting such targets in a relatively short period of time is not feasible. Also, policymakers are cautious about enrolling beneficiaries too quickly because of California's experience in the 1970s with enrolling beneficiaries in prepaid plans, which was marked by abuses among some providers.

Hospital Contracting Contracting by the state's Medical Assistance Commission for hospital services encompasses almost all areas in the state; 92 percent of Medi-Cal hospital expenditures are paid for under hospital contracting. The state's Medi-Cal policymakers perceive hospital contracting as an interim measure to control a large component of Medi-Cal expenditures until a greater proportion of beneficiaries are enrolled in models like the county-organized health systems and prepaid health plans.

Chapter Three

Implementation of the Demonstration

A. Case Management

Under a case management system, physicians are to serve as a point of access to the health care system for the beneficiary. The case manager also is to make all referrals for specialty care, tests, prescription drugs, and hospital inpatient care. Under the Santa Barbara model, the case manager is also at some financial risk. Solo and group practice physicians and the county health services serve as case managers. The county is the case manager for approximately 25 percent of all persons eligible for Medi-Cal.

Eighty to eighty-five percent of all persons eligible for Medi-Cal are referred to as Class I beneficiaries. These are patients who can be case managed and who select a primary care physician or the county health department to serve as case manager. If a person does not select a provider, the Authority assigns the patient to a physician through the management information system's auto assignment program. The patient's freedom to choose a provider at that point is limited but the patient is assured of access to such a provider. The remaining 15-20 percent of persons eligible for Medi-Cal are referred to as Class II beneficiaries. These beneficiaries are persons whose medical conditions make it inappropriate for physicians to case manage them and to be at financial risk for the care they need.

Point of Access Some case managers report that they are more readily available to patients under the Initiative than under the traditional Medi-Cal program. For example, they are more likely to see patients during non-office hours if a patient goes to an emergency room in a non-emergency situation and hospital personnel notify them. Some case managers say that the financial responsibility they bear in caring for the patient gives them the impetus to see patients during non-office hours.

Under the terms of their contract with the Authority, physician case managers are to be available directly or through a group arrangement to their patients 24 hours a day. There have been some instances in which case managers were not available when emergency room personnel tried to contact them to determine whether care should be rendered by the emergency room physicians. The lack of availability is attributed, in part, to the failure of physicians' answering services in the county. The Authority has reiterated the need for case managers to be available on a 24-hour basis in its provider newsletter.

Some physicians and hospital emergency room personnel have had difficulty determining if a patient who comes for care is eligible for the program. Patients do not always have their cards which identify them as patients enrolled in the Initiative. They have also had difficulty finding out the name of the physician who serves as the patient's case manager. To verify eligibility and case manager the physician is to contact the Authority. Until recently the Authority gave eligibility information only during office hours during the week. On

October 1, 1984 the Authority expanded its hours to include evenings and weekends, during which physicians can confirm a patient's eligibility for the Initiative and identify the patient's primary care provider.

Referral Services Utilization trends for the first operating year indicate that referrals to specialists have declined. Two reasons account for the decline: a decrease in the number of patient self-referrals and a decrease in the number of referrals made by physician case managers. Case managers attribute the decrease in referrals primarily to the decrease in patient self-referrals but they indicated that the decrease is also a consequence of their scrutinizing more carefully the referrals they make. Specialists indicate that referrals to them have decreased. One specialist expressed concern that Medi-Cal patients were coming to him in later stages of illness, although the consequences were not life-threatening.

Several advocates for the developmentally disabled expressed concern that patients who have the county health department as their case manager and who reside in the north part of the county must wait longer before they are able to receive referral care in non-emergency cases. The county health department conducts a certain specialty clinic, for example, every two weeks. Advocates asserted that patients in need of that specialty care need to wait, whereas under the traditional Medi-Cal program patients could receive care sooner.

Also, advocates asserted that patients who have the county health services as their case manager and who need elective

surgery may be required to receive their care at Cottage Hospital, which is in the southern part of the county, one and a half hours away. The state auditors who conducted a medical audit of the Initiative were concerned that because of this distance, some patients do not have the same ease of access to care as Medi-Cal patients who live in the southern part of the county. Some observers point out that this problem of access in the north part of the county is a function of the distribution of physicians in the county and not a characteristic of the Initiative or the inadequacy of case management by the county health department.

There is evidence to suggest that some physicians serving as case managers may not be reporting all patient visits. In such instances the physician and the Authority do not have accurate information on care that is being rendered, which is necessary for quality assurance, good case management, and rate setting. The Authority staff is considering a schedule of sanctions against those providers who do not routinely provide this information.

Changing Case Manager Patients can change case manager only if certain conditions are met:

- o a patient moves away from the case manager's service area
- o a patient's prior physician participates in the program who would be more suitable for the patient
- o the patient files a grievance which is resolved by reselecting a case manager
- o a young patient outgrows the need for a pediatrician

- o a patient is auto assigned to a case manager and chooses another case manager within 20 days
- o a physician terminates participation or has certain practice restrictions
- o access to the case manager proves to be difficult for the patient

The Authority is reluctant to have open enrollment for 21,000 potential eligibles because of the administrative burdens it would bear. Unlike some programs which have a few prepaid plans that serve as case managers, patients could choose from among about 100 case managers. The administrative and technical problems the Authority experienced enrolling patients at the beginning of the program required staff to spend months processing the changes that resulted from patients reselecting case managers when the initial choices were inappropriate or unsatisfactory, and when new case managers joined the program after the program began. The process required staff to update the information system and notify providers of the changes. Hence, the Authority is reluctant to have an open enrollment period and perceives that the grievance process offers sufficient opportunity for patients to change their case managers.

B. Utilization Controls and Quality Assurance

The structure of the Initiative includes a two-tiered system of utilization controls: the financial incentives for case managers and the utilization review system. The utilization

review system helps the Authority to monitor the quality of patient care.

Financial Incentives Each primary care case manger has a trust account to which a capitation payment is credited monthly for each patient, based on the person's age, sex and eligibility category. The full capitation payment is to cover hospital, referral, pharmacy, lab and x-ray and primary care services. A portion of this full capitation is the primary care capitation, which is the projected cost of providing primary care services to the recipient. The case manager receives an up-front guaranteed monthly payment of 80 percent of the primary care capitation. Twenty percent of the primary care capitation is allocated to the reserve.

Debits are made against the physician's full capitation account for any of the above services provided or authorized by the primary care physician. If at the end of the year the primary care physician's full capitation account has a surplus or credit balance, the case manager receives up to 20 percent of the primary care capitation (the reserve amount). If a surplus still remains in the physician's trust account after the reserve distribution, the physician shares the surplus equally with the Authority. If the trust account has a deficit, the primary care physician does not receive the withhold of 20 percent reserve of the primary care capitation. The withhold amount is reduced dollar-for-dollar by the amount of the deficit but the full amount of the 20 percent withhold is the maximum the physician can lose.

The county health department also serves as a case manager for about 25 percent of the Medi-Cal beneficiaries. Like the primary care case manager, the county has a trust account to which full capitation payments are credited for hospital, referral, pharmacy, x-ray, and lab services. But the county is at greater risk than the primary care physician. It receives a partial monthly capitation payment which is projected to cover the cost not only of primary care but also referral, lab and x-ray, transportation, and durable medical equipment services. Twenty percent of this amount is withheld each month. Just as the primary care physician is to provide all primary care services within the primary care capitation, the county is to provide all of the above services within the partial capitation. Debits are made against its trust account for all of the services provided and authorized by the county. If the trust account has a surplus at the end of the fiscal year, the county health department can receive up to 20 percent withhold and shares 50 percent of remaining surplus with the Authority. The maximum the county can lose is the 20 percent withhold.

Payments made to skilled nursing facilities and intermediate care facilities are not included in the capitation payments made to the case managers, who are therefore not at risk for long-term institutional services.

Physicians who have fewer than 125 patients participate in a shared risk pool or trust account. The risk pool protects physicians from undue risk that can be associated with having a small number of beneficiaries over which the risk can be

spread. About 51 percent of the case managers who have 5.5 percent of Class I beneficiaries are in this category. As a group, these physicians share savings or losses with the Authority.

During the first year, the case manager was at risk for all expenditures per patient up to \$15,000. The state was at risk for claims that exceeded \$15,000. During the year, a number of patients incurred expenditures that exceeded the \$15,000 risk limit, which was substantially more than the state had projected. During the course of the year, the Authority agreed to split the risk with the case manager, such that the case manager was at risk for the first \$7,500 of expenditures per patient. Case managers shared the risk for the remaining \$7,500.

In the second year, the state set the maximum risk for the Authority and the case manager at \$25,000. Individual case managers are at risk for the first \$7,500 per patient per year; all physician case managers share the risk for expenditures of \$7,500-\$15,000 per patient. The Authority assumes the risk for the remaining \$10,000.

Utilization Review The Authority has established a three-tiered system of utilization review: prospective, concurrent, and retroactive. Prospective review is conducted by means of referral authorizations and treatment authorization requests. With the exception of emergencies and certain services, all services provided to beneficiaries must be authorized by the case manager. If a case manager refers a patient to another

physician for a consultation, the case manager must complete a referral authorization form. The form contains diagnostic and treatment orders authorized for a particular patient. One copy of the form is kept by the case manager for internal records, one copy is mailed to Jurgovan and Blair, Inc., the fiscal agent, to match with the referral provider's claim (no claim is paid unless there is a referral authorization), and one copy is sent to the referral provider. A referral authorization is not required for those services that do not require the participation of another physician, for example, prescriptions, lab tests, or x-rays.

To refer patients for certain services, such as elective inpatient hospital care and equipment, such as wheelchairs, the case manager also must receive prior authorization from the Authority. The Treatment Authorization Request System (TARS) requires the medical department to review and assess the patient's needs for the prescribed services. The TARS system is used statewide by the Medi-Cal program and has been adopted by the Authority to review elective services for medical necessity and cost-effectiveness.

Concurrent review is conducted through on-site review at hospitals and skilled and intermediate care facilities. Length of stay is assessed according to medical necessity, based on severity of illness and intensity of services required. On-site reviews may also be conducted at a patient's place of residence to assess the need for medical supplies and equipment.

Retrospective review is conducted by means of peer review and internal review of reports from the management information system. The first medical Peer Review Committee meeting was held on January 16, 1985. Nine physicians, including the chairman of the board of directors of the Authority and the past president of the county medical society serve on the committee. The committee focused on patient outcomes. On March 20th, the Peer Review Committee reviewed hospital admissions to determine the stage of illness at the point of admission and if an admission could have been avoided or length of stay shortened by providing different ambulatory care prior to admission. The peer review committee reviewed 21 charts. One of the chart reviews found, for example, that a patient was unnecessarily admitted into a hospital. The case manager cited social and psychological reasons rather than medical reasons for the admission. According to the Medi-Cal definition of medical necessity, this admission was inappropriate. The committee suggested that the onus for appropriate placement is on the hospital and case manager.

On May 16, 1985, the Peer Review Committee reviewed readmissions within seven days of discharge. The Committee is reviewing charts chosen on a sample basis and is learning sampling techniques. It is also considering producing a newsletter with findings and recommendations. The peer review committee also reviewed the charts of case managers who had the largest surpluses and found no indication of poor quality care.

For internal review, the Authority reviews reports that are produced by the management information system which identify trends in the use of health care services. For example, in September 1984, the Authority's Medical Department reviewed emergency room claims for appropriateness of billing and case manager contact. This process showed that random sampling of those claims helped to pinpoint concerns about the quality of care provided and billing problems. The Authority is establishing a procedure with JBI so that this review can be implemented on a regular basis. In addition, the management information system produces reports called exception reports that identify all the case managers and their utilization rates per 1000 beneficiaries. The Authority can compare the utilization rates among physicians and highlight those case managers who may be over or under-providing care.

The Quality Assurance Committee, to which the Peer Review Committee reports, has met since February 1984. The Committee has reviewed referral patterns, the quality of care at county clinics, patient charts for legibility and organization, grievances which may be related to quality concerns, appropriateness of denials of TARS, and patient satisfaction.

State Medical Audit In February 1985 the state conducted an audit of medical and financial activity. The auditors found that proper accounting controls were in place. Generally, the auditors found no major problems in their medical review, which focused on process rather than patient outcomes. An exit

interview with the Authority included some points that require redressing:

- o incomplete medical records; county physicians tended to have better chart documentation
- o lack of chart documentation for follow-up on hospital care, referrals and missed appointments
- o concern about one physician's performance in regard to over-prescribing narcotics for pancreatitis and rendering possible substandard care (several physicians in the community were aware of this situation)
- o physicians lacking written evidence of up-to-date Drug Enforcement Administration (DEA) licenses
- o concern that the county health department's policy requires some patients in need of elective acute hospital care to go to Cottage Hospital in Santa Barbara even though the patient's place of residence is in the northern part of the county, one and a half hours from the hospital; auditors were concerned that some patients in the north part of the county may not have equal access to health services.

The Authority's Quality Assurance Committee has made some similar findings. Charts of the physicians in question will be reviewed. All physicians now have evidence of DEA licensure. The Authority is preparing a formal response to the auditors exit interview.

C. Utilization Trends As of February 1985, the Authority calculated the following utilization trends during the first operating year (ended 9/30/84) and compared them with utilization trends in Santa Barbara under the Medi-Cal fee-for-service system prior to the Initiative:

Trends in Utilization

<u>Type of Service</u>	<u>Services Per 1000 Beneficiaries Year 1 Under Health Initiative</u>	<u>Services Per 1000 Beneficiaries For Year Prior to Health Initiative*</u>
Physician Encounters	2763	3159
Emergency room visits	311	Not available
All Hospital Outpatient Services	1088	3024
Prescriptions	6234	7392
Inpatient Discharges	186	Not available
Inpatient Days	1335	1631
Average length of stay	5.79	Not available

*Includes some data on the medically indigent adults (MIA) who are no longer eligible for Medicaid and therefore not enrolled in the Health Initiative.

Source: Santa Barbara Health Authority

The average length of stay of 5.79 days under the Initiative compares to the statewide average for all patients regardless of payer of 6.6 days in 1984. This figure represents a decrease of about 3 percent from 1983 when the statewide average length of stay was 6.8 days. Also, there was a 3.7 percent decrease statewide in patient days from 1983 to 1984, whereas there was a 26 percent decrease in patient days under the Initiative.

As of June 1985, hospital inpatient expenditures are 13 percent behind projections, on a year-to-date basis. This represents approximately \$1.16 million under budget.

D. Financial Status as of March 1985

Fiscal Year One At the end of the first fiscal year, the Authority estimated that over \$1 million in surpluses remained in the case manager trust accounts. About 70 percent of the case managers had some surplus in their trust accounts, ranging from \$24 to \$180,000. After accounting for this surplus, the Authority also had risk reserves totaling \$520,000 funded from interest earned on cash-on-hand. The amount of unrestricted funds or "profit" remaining from the first year of operations after accounting for the risk reserve was approximately \$400,000. A financial audit, conducted by Peat, Marwick, and Mitchell, confirmed a balance in unrestricted funds after funding the risk reserve.

Financial Statistics Year Ended August 31, 1984

<u>Expenditure</u>	<u>Santa Barbara Health Initiative Expenditures Per Eligible Per Month</u>	<u>Santa Barbara Medi-Cal Expenditures Prior To Health Initiative</u>
Primary Care Physicians	\$10.42	
Specialist Physicians	8.57	\$16.89
Pharmacy	6.12	6.80
Hospital Inpatient	29.60	43.54
Hospital Outpatient	3.73	5.04
Long-Term Care	23.89	21.26
Other Providers	3.28	9.43
Total Health Care Expenditures	85.61	102.96
Administrative Expenditures Per Eligible Per Month	7.99	
Allocation to Risk Reserve Per Eligible	1.92	
Total Expenditures Per Eligible Per Month	95.52	
Total Revenues Per Eligible Per Month	96.89	
Balance Per Eligible Per Month	1.37	

Fiscal Year Two In March 1985 the Authority projected a \$658,000 deficit for the second fiscal year. Not deducted from this projected deficit was interest income from cash on hand, which is being used to fund the risk reserve. Subtracting the projected interest income from the overall deficit was calculated to be approximately \$250,000.

The Authority claimed that the major, though not only, reason for the deficit was the fact that the fee-for-service

base, from which its 95 percent capitation is calculated, has been shrinking. This base is the amount the state projected would have been spent in Santa Barbara county under the traditional fee-for-service program. The shrinkage is attributed to hospital contracting and decreases in provider reimbursement. Moreover, the decrease in the number of Medi-Cal eligibles in the county allows administrative costs to be spread over fewer beneficiaries.

The state and the Authority went through numerous reiterations of proposed rate packages. The states first rate package for the second fiscal year was proposed to the Authority in September 1984, after the second year had begun. The Authority argued that the rates were insufficient. The state agreed later in the fall of 1984 to offer the Authority 97.8 percent of the fee-for-service base, acknowledging the shrinkage in that base. This agreement, which had to be approved by HCFA because it is a change in federal policy regarding demonstrations, was rejected by HCFA. The state withdrew the proposed rate of 97.8 percent of fee-for-service and developed another proposed rate package based on 95 percent of fee-for-service. The Authority would not accept this rate package. Thus, as of the beginning of March 1985, the Authority and the state could not agree on the amount that the state should pay the Authority for the second operating year, which was already half over. The Authority proposed several adjustments that could be made to increase the base to which the 95 percent factor would be applied. The suggested

adjustments highlight some of the issues the Authority is trying to address.

E. Proposed Adjustments in State Payment

Certain Eligibility Groups The Authority has found that it is not able to case manage and reduce expenditures for certain groups of eligibles, even though it is at risk for the cost of the care they receive. These groups are primarily Class II beneficiaries who cannot be appropriately included in a primary care case management program in which providers are at financial risk. These Class II beneficiaries, who account for 15-20 percent of all persons eligible, include those who have retroactive eligibility, bear a share of the cost of the care that is rendered, are eligible for California Children's Services, receiving long-term institutional care, are certified dialysis patients and out-of-county residents. The Authority estimates that it cannot control the cost of care for about 3,000 of its beneficiaries. It requested that the state pay 100 percent of the costs incurred in caring for these groups of eligibles.

Administrative Costs The Authority also requested that the state reconsider its payment for administrative costs. The Authority claimed that according to its enabling legislation, it should receive 95 percent of fixed and variable administrative costs. During the first-year negotiations, the Authority received 95 percent of variable costs. The state did not agree to give it 95 percent of fixed costs, arguing that these costs would be incurred nonetheless by the state. The state payment

to the Authority for administrative costs totaled \$300,000 for the first year. The Authority calculates its administrative costs for the first year to have been \$2 million, or 9 percent of total program revenues.

Based on its actual administrative expenditures for the first year the Authority requested that the state make additional payments to cover administrative costs during the second year. The state agreed to pay only variable administrated costs only for the first year of operation since the Authority initially maintained that program savings would cover administrative costs in the second year.

Interest Expense The Authority also argued that the state should consider making an adjustment for interest rates charged to the Authority. Currently, the state adjusts the capitation payments to the Authority for the cost of foregone interest income. Because the state has to make "up front" payments to the Authority rather than pay claims three months after the service is rendered, it foregoes three months of interest income. The Authority claims that now because interest rates are lower, it should be charged rates lower than the rates projected at the time the rate package was offered in 1984. The Authority calculates that every one percentage point increase in the interest rate charged cuts the state's payment to it by \$250,000. The state's view is that it would have been at a disadvantage if interest rates had increased rather than decreased. Fluctuations in interest rates, therefore, are part of the risk that the Authority and the state both bear.

Long-Term Care The Authority also sought an adjustment for long-term care expenditures. Given that ICF beds have been upgraded to SNF and ICF-DD beds and several new ICF-DD beds have been licensed, the Authority was seeking an upward adjustment in rates. It argued that it would incur higher costs for patients in those facilities that have been upgraded and newly-licensed, for which there is no historical cost. These costs were not reflected in the fee-for-service base which was developed using data that do not account for the upgraded and newly-licensed facilities.

The state points out that if patients were receiving the level of care they should have been receiving before facilities were upgraded, then the Authority should not have to request additional funds. Yet, 24 ICF beds were upgraded to SNF beds, which leaves no licensed ICF beds in the county. There is no alternative place for these patients but the SNF, which commands a higher rate.

The Authority also argued that the licensure of the new ICF beds for the developmentally disabled will present an additional expense. Because the beneficiaries who are now in the facility had been inappropriately residing in a board and care facility which is not reimbursable under Medi-Cal, the fee-for-service base would not include the expenditures to care for these patients.

Resolution After the Authority's board of directors had postponed a vote (at state urging) on whether to terminate its contract with the state, the state came forward with an offer of

an additional \$354,000 to offset a portion of the projected deficit for the second operating year. These funds cover the \$250,000 projected deficit in the second year. The board agreed to use the unrestricted funds from the first year to offset the additional part of the projected deficit in the second year.

In addition, the state agreed to pay for additional expenditures the Authority incurs because of mid-year increases in Medi-Cal provider rates mandated by the state legislature. The Authority projects a loss of \$236,000, however, for increases in pharmacy and SNF rates that will not be paid by the state. The Authority has to pay the additional cost, with funds from the original capitation payment. The state agreed that it would include the expenditures associated with these and other benefits in the rates for the next year

The reason the state offered the additional funds was to encourage the board of directors to continue the program. The state believes that it has a great deal at stake in the county-organized system model. If the Santa Barbara Initiative ceased operation, following the termination of the Monterey County demonstration (for very different reasons), it would have a difficult time convincing state legislators and other key policymakers of the benefit of its thrust in Medi-Cal reform.

F. Rate Setting

The state's rate development process requires a number of steps. First, it determines the fee-for-service base, to which the 95 percent that is allowed for the demonstrations is applied.

To develop the fee-for-service base, the total incurred costs in fiscal year 1982-1983 are calculated. For some eligibility groups, data for Santa Barbara county are used; for categories in which there are few eligibles, statewide experience is used. Because Santa Barbara has different costs per eligible than the state generally, the statewide data that are used are adjusted to reflect Santa Barbara's lower cost experience. The fee-for-service base also is adjusted to reflect changes in Medi-Cal benefits and levels of reimbursement. Another step requires the capitation to be reduced for expenditures above the \$25,000 risk limit that the state bears.

G. Substitution Effects

Cost-Effective Treatment The Authority also has flexibility to offer benefits which Medi-Cal does not offer. With this flexibility, it can provide care that may require an up-front investment but which, in the long run, substitutes more appropriate, lower-cost care for more costly care. In one example, a patient in the Initiative would have been placed in a nursing facility under Medi-Cal because of a certain condition. The Authority decided to pay for rehabilitation services for the patient, which Medi-Cal would have disallowed. This substitution enabled the patient eventually to be cared for in a home environment rather than a nursing facility. Thus, the up-front expenditure resulted in better and lower-cost care in the long run.

Clinitron Beds The Authority is attempting to develop lower-cost, alternative forms of care for bedridden patients who are subject to skin breakdowns or decubitus. It is making an up-front investment in Clinitron beds which prevent skin breakdowns and frequent hospitalizations with air fluidized therapy.

Home Care The Authority has contracted with a hospice to offer home care to patients. It is also paying for chemotherapy, intravenous antibiotic therapy for osteomyelitis, and phototherapy for newborns.

Discharge Planning The Authority is currently working with hospitals in the county to set up a better discharge planning program for patients.

Administrative Days The Authority also has attempted to reduce hospital administrative days. It has negotiated rates with SNFs to provide a higher level of care for patients, who need more than the care usually provided by such a facility, but who do not need to be in a hospital. In November 1983, there were 377 unnecessary administrative days of care. The number of days dropped to 177 in November 1984. Likewise in December 1983, administrative days numbered 232; this dropped to 96 in December 1984. The factors accounting for this decline include cooperation between the Authority's on-site nurses and hospital discharge planners, the availability of the Clinitron bed, and changes in the hospital reimbursement rate.

H. Other Cost-Saving Efforts

The Authority has identified a number of other areas where it could save program dollars.

Pharmacy Use Case management and management information system reports have allowed the Authority to identify about 40 patients who abuse pharmacy benefits, sometimes leading to their receiving unnecessary controlled substances. Those patients who are eligible for both Medicare and Medicaid, for example, can go to a pharmacist to get a prescription that has been authorized by a physician who does not know that the patient has a Medicaid case manager.

To correct this problem of lack of oversight of prescription drug use, the Authority is in the process of issuing certain beneficiaries restricted pharmacy cards. It will identify potential abusers by reviewing comments from physicians and pharmacists, and patient profiles of high users. Such restrictions may require all prescriptions to be prior approved by the Authority and the case manager before being filed.

Expanded Formulary The Authority has expanded the Medi-Cal drug formulary for reasons of efficacy and cost-benefit. Physicians can prescribe more medications such as beta blockers, non-steroidal anti-inflammatory drugs, that may be more appropriate for the patient's needs without prior authorization. Physicians and pharmacists have been invited to offer suggestions on additions to the formulary. These suggestions are reviewed by the Authority's Formulary Advisory Committee.

Durable Medical Equipment The Authority has hired, on a consulting basis, a specialist in durable medical equipment to review requests and repairs for durable medical equipment. Such a specialist will be able to inform the Authority if alternative, less expensive equipment is available that would suit the patient's needs. Also, the specialist can inform the Authority whether repair or replacement of durable medical equipment would be more cost-effective.

Transportation The Authority will soon be contracting with a cab company to transport patients in need of care, for example, renal dialysis patients. The rate for the cab company is substantially less since it does not charge separate fares when transporting multiple passengers. The current transporting services charge separate fares, which is allowed by Medi-Cal regulations. This charge is expected to result in some savings to the Initiative.

The Boundaries of Cost Savings The board of directors of the Authority has indicated that it will not reduce providers' reimbursement, nor will it selectively contract with hospitals because it believes that selective contracting limits patient access to health care facilities. Moreover, the Authority believes that the rates that could be negotiated with hospitals on a selective basis would not be any lower than the rates negotiated under the Initiative.

I. Management Information Systems

Jurgovan and Blair, Inc. is serving as the Authority's fiscal agent. It has had difficulty generating management reports needed by Authority staff, such as the Quality Assurance subsystem reports. This is partially attributed to the Authority's delay in finalizing the reports that it needs to perform quality assurance and utilization review. Also, as of the site visit, there was a payment backlog of 20,000 claims because of JBI staffing problems.

Reports to Case Managers Case managers receive a primary physician account (PPA) statement on a monthly basis. The statement reflects all activity associated with the account for a given month and on a year-to-date basis. In addition to reporting on claims paid, the report contains information on amounts which may be ready for payment or which may be awaiting internal review or audit. There is also a monthly estimate of claims incurred but not yet received by JBI from referral providers. The Authority recognizes that this information is an essential indicator of the financial condition of a capitated system. It has also acknowledged the difficulty it has had in estimating these claims, in part because the Authority has had no prior experience on which to base its estimates.

In addition to this report, 19 other reports are available to the case manager. Each report provides additional information to support the summary totals on the monthly account. Tier I reports are provided on a monthly basis, while Tier II and Tier III reports are available upon written request. Tier I reports

include capitation credits and amounts paid and accrued on a year-to-date basis; Tier II accounts include those that elaborate on paid claims, pended claims, and claims payable; Tier III reports offer a profile of services provided by recipient and expenditures incurred but not yet reported.

J. State Relations

The Authority perceives that the Department of Health Services (DHS) may not be as fully committed to the demonstration as it could be. For example, only two days before the board of directors were to vote on whether to terminate the contract with the state, did DHS officials go to Santa Barbara to determine if mutually satisfactory arrangements could resolve the board's concerns about continuing the program under projected deficits.

Regarding daily program operations, while the state has helped the Authority work out numerous "glitches" in the operation of the program, a number of outstanding administrative issues still remain to be resolved to help the Authority run the demonstration more easily.

Processing Risk Limit Claims Risk limit claims are those claims which exceed the first \$15,000 of expenditures per eligible per year. According to the contract between the state and the Authority, these claims are to be paid by the state. Adjudication of these claims has been consistently slow, which has a negative effect on the Authority's cash flow.

Notification of Eligibility The eligibility files that the state uses to determine eligibility for the Initiative are sometimes inconsistent and not up-to-date. Because of these discrepancies and delays, the Authority is sometimes unaware of beneficiaries' eligibility, particularly for those beneficiaries who reside outside the county but are eligible for the Initiative. (This occurs among some SSI beneficiaries for whom the SSI payee is the Tri-County Regional Center for the Developmentally Disabled which is located in Santa Barbara County). Medi-Cal cards are sometimes issued by the state and the County Social Services Department without the Authority having eligibility information. Claims payment is often delayed until the Authority can verify eligibility which frustrates physicians and delays cash flow.

Cooperation with State Field Offices The Authority has had difficulty managing care for those patients who, for example, are placed in a skilled nursing facility outside the county. It has asked the state field offices, which administer the Medi-Cal treatment authorization request system, to review the medical necessity of the care received by these beneficiaries. The Authority is unable to commit its staff to travel such distances to review patient care. This issue remains to be resolved.

Chapter Four

Provider Perspective

A. Physician Reaction

In the fall of 1984 the Santa Barbara County Medical Society conducted a survey of all physicians in the county to assess their opinions on the Initiative. Most respondents perceived that the Authority staff was more accessible and responsive to physician concerns than the state administrators of the Medi-Cal program. For example, physicians can call the Authority staff who have their offices there in Santa Barbara rather than state staff in San Jose to have their TARs approved. In this way, physicians can have the opportunity to know the staff that makes decisions on whether or not care should be rendered. Physicians seem to prefer this local administration rather than dealing with the anonymity of the state administrators.

However, about one-half of the physicians who responded thought that the Initiative was worse than the state-wide Medi-Cal program. Also, physicians perceived that patients' access to primary and specialty care had been reduced. Primary care physicians and specialty physicians expressed similar views of the program.

Several persons interviewed expressed concern about drawing valid conclusions about the survey, however. First, 40 percent of the physicians who completed the survey were not

participating in the Initiative. Some observers contended that these physicians had little basis on which to judge the program. Others pointed out that the survey was conducted before the end of the first year, prior to the distribution of physician surpluses. Accordingly, physicians would most likely have had a more favorable impression of the program had the survey been conducted after the distribution of the trust account surpluses. Moreover, since the distribution of the trust fund account surpluses, more physicians have signed contracts with the Authority.

In addition, the PPO and HMO activity in Santa Barbara county that emanates from pressure from payers and from the high physician population ratio, appears to give physicians impetus to look more favorably upon the prospect of participating in the Initiative. In fact, this pressure is one of the reasons that the board is considering whether it should expand the operation of the Initiative to include Medicare-only beneficiaries. There is concern that if the independent physicians do not make themselves available as a group to serve Medicare beneficiaries they will lose them to other providers.

Other physicians in the community are reluctant to participate in the Initiative because of the relatively low reimbursement rate, the volume of paperwork required to file claims, the need to get prior authorization for certain services, and fear of malpractice charges. These same reasons, however, can account for physicians not participating in Medi-Cal prior to the Initiative.

B. Distribution of Beneficiaries Among Case Managers

The three largest case managers are the three county health department clinics: the Santa Maria Clinic, the Santa Barbara Clinic, and the Lompoc Health Clinic. The fourth largest case managers are two pediatricians who have 819 beneficiaries. Slightly more than 50 percent of the case managers have fewer than 100 patients, with the remaining case managers having more than 100 patients. The breakdown of patients per case manager as of December 14, 1984 is as follows:

<u># of Beneficiaries</u>	<u>Number of Case Manager Contractors With Given Number of Beneficiaries*</u>
1- 25	24
25- 100	27
100- 199	18
200- 299	7
300- 399	4
400- 499	6
500- 599	2
600- +	<u>5</u>
	93

* A Contractor may consist of one or more physician case managers.

C. Financial Status At the end of the first fiscal year, approximately 70 percent of the case managers who had more than 125 patients received some surplus in their trust accounts. The surpluses ranged from \$24 to \$180,000. Pediatricians and general practice case managers received the greatest dollars per beneficiary of all the case managers. Generally, obstetricians

and gynecologists were the case managers who did not end the year with a surplus. Two factors account for this: they do not practice primary care and therefore have to refer more patients than primary care physicians; they tended to have more women of childbearing age as enrollees which would put them at greater risk for prenatal care, deliveries and post natal care. This fact contributed to the Authority's decision to no longer have case managers at risk for obstetrical care in the second fiscal year.

The case managers who have fewer than 125 beneficiaries and who were in the shared risk pool fared differently. The shared pool had an overall deficit although some physicians incurred surpluses. Authority staff attribute the deficit to two factors: less incentive for physicians who have fewer patients to make a change in how they refer patients; a greater possibility of having a few high cost patients who may cause an overall deficit. One case manager, for example, had a substantial surplus in the middle of the fiscal year but two patients' illnesses brought the physician's account into a deficit.

D. Policy Changes Regarding Physician Participation

The Community Advisory Board in the northern part of the country expressed concern regarding access to primary care in the St. Ynez Valley. The board of the Authority decided, after much deliberation, to modify temporarily terms of the case manager contract. This was agreed to, in order to encourage a

physician in St. Ynez Valley who would participate only under certain conditions, to sign a contract with the Authority. Some board members expressed concern that if concessions were made to one potential case manager other case managers would demand concessions as well. Others believed that the need for another physician to serve Medi-Cal beneficiaries overrode the concern with maintaining a consistent policy.

E. Hospitals

Hospitals have several concerns regarding the impact of the Initiative on their financial status. One hospital experienced a decrease in Medi-Cal patients because doctors with privileges at those hospitals did not contract with the Authority. Other hospitals were concerned about the rates offered to them by the Authority but lacked the data to dispute the Authority's methodology.

During the second year the Authority changed the way it paid hospitals. Rather than paying them on a two-tier per diem basis for acute and administrative days, the Authority developed additional rate categories based on the care rendered. Rates were developed for acute, obstetric, nursery and administrative days.

The Authority also added an amendment to the hospitals' contract to permit the denial of payment when hospitals fail to make, or attempt to make, contact with care managers within 24 hours of their patients' receiving emergency care. This procedure was implemented to respond to hospitals' not

notifying case managers when patients received emergency care, which precludes effective case management.

F. Home Care Providers The Visiting Nurses Association of Santa Barbara County (VNA) expressed concern that the Authority requires them to "excessively document" the need for patient care before it will approve the Treatment Authorization Request submitted by the case manager. For example, if a physician submits a TAR for physical therapy for a patient at home, the Authority will question why the patient could not be seen at a hospital outpatient facility or in a clinic. The VNA has to document that the patient is homebound and cannot travel to a facility to receive care.

The VNA also expressed concern that an inordinate number of TARs for home visits for occupational therapy were being denied. Also, they indicated that there is poor hospital discharge planning and insufficient instruction on patient self-care. The Authority points out that Medi-Cal's benefits for occupational therapy are limited, which is reflected in the denial of TARs.

G. Providers for the Developmentally Disabled

One of the providers of intermediate care for developmentally disabled persons has found it difficult for its patients to gain access to orthopedic care under the Initiative. This difficulty is attributed to the fact that very few orthopedic physicians have signed contracts with the Authority.

Consequently, the provider is paying for orthopedic services rendered by private physicians rather than having its patients receive care under the Initiative.

H. Provider Newsletter The provider newsletter, which is issued several times a year, has been an important vehicle for conveying information. Issues have addressed topics including:

- o amendments to providers' contracts
- o policies for notifying case managers in cases of emergency treatment
- o appropriate use of the referral authorization form
- o highlights of professional advisory board meetings
- o who providers can call if they have a question about the Initiative

Chapter Five

Consumer Perspective

The social workers at the Tri-County Regional Center for the Developmentally Disabled are the most vocal group of advocates for Medi-Cal beneficiaries. They articulated several concerns regarding the Initiative. About 125 to 150 of their clients are enrolled in the Initiative but do not reside in the County. They are eligible for the Initiative because the state considers patients associated with the regional center, which is located in Santa Barbara County, residents of Santa Barbara regardless of the patient's county of actual residence. These policies have complicated the administration of the Initiative.

A. Reactions of Consumer Advocates

The consumer advocates expressed concern about the Initiative regarding access to health care services outside the county as well as in the county.

Out-of-County Providers Some providers practicing outside the county are not familiar with the Health Initiative eligibility card which identifies patients as Medi-Cal recipients enrolled in the Initiative. Hence, advocates for the developmentally disabled allege that some of their clients have been denied care by providers who think that they will not be reimbursed for services that they render.

To resolve this problem, the Authority and regional center representatives worked out a system to notify out-of-county

providers about the program and the procedures required to receive reimbursement. The Authority is also encouraging providers who work outside the county and who occasionally see patients who are enrolled in the Initiative to sign a contract to participate. The Authority also has developed informational letters for beneficiaries and their guardians when they may be relocated but still be enrolled in the Initiative. Also, the regional center is trying to establish Medi-Cal eligibility for non-Santa Barbara residents in the county where they reside. The process, though, is lengthy and only a few patients have had their place of Medi-Cal eligibility changed.

Access in the County

The advocates for the developmentally disabled also point out that while physicians are reluctant to take care of developmentally disabled persons under Medi-Cal generally, they perceive that access to physicians for some patients under the Initiative is more difficult to obtain. Anecdotal evidence highlights some of the difficulties patients may have in gaining access. In the north part of the county, where there is only one practicing neurologist, the neurologist could not effectively work with the developmentally disabled patient. Therefore the patient had to travel one and a half hours to Santa Barbara to receive care. The consumer advocates acknowledge that this is a problem not solely of the Initiative but indicates the lack of certain specialists, generally, in the more rural northern part of the county.

Negotiating the System Advocates of the developmentally disabled also note that the controls on the use of the health care system, which are crucial to the success of the program, may act as a barrier to care for those patients who are less able to negotiate the system of controls. They believe that certain beneficiaries are confused by the new program and therefore need to be "walked through" the system to assure that they receive needed care. The advocates perceive their role as crucial in following through on grievances their clients submit to the Authority.

Participation in the Process The consumer advocates spoke favorably about their access to the Authority staff. They indicated that the Authority staff is responsive to the concerns that they raise regarding patient access. For example, the staff worked with the advocates in establishing a process to inform out-of-county providers about the Initiative. The advocates also serve as members of the Initiative's Community Advisory Boards, which offer them additional access to the workings of the Authority.

B. Grievances

The grievance process affords a broader view of the beneficiary perspective. In 1984, 484 grievances were filed by patients. A summary of the grievances shows trends in the nature of the grievances. Many of the grievances result from patients' dissatisfaction with case managers. The Authority's grievance coordinator attempts to resolve the problems

informally, and then resorts to a more formal procedure if the grievances remain unresolved. The volume of grievances is attributed, in part, to the accessibility of the grievance system and the grievance coordinator.

Nature of the Grievances Of the grievances filed,

- o 17 percent, were filed by patients because they were billed inappropriately for services rendered by physicians.
- o 30 percent of the grievances were filed by patients who were not satisfied with the care they received.
- o 27 percent were filed by patients dissatisfied with their auto-assigned case manager or who had eligibility verification problems
- o 11 percent of the complaints were filed when the beneficiary's health care may have been hampered or delayed by lack of reliable transportation
- o 11 percent of the grievances were associated with obtaining medical equipment and prescription drugs, and alleged discriminations because of Medi-Cal status
- o 5 percent of the grievances were associated with a beneficiary's discontent with the personal or environmental aspects of a medical facility.

These grievances were forwarded to the medical director who found no indication of poor quality care.

Geographic Patients in the southern part of the county tend to be more satisfied with the program than their counterparts in the northern part of the county. The Authority attributes this trend to the fact that Medi-Cal recipients residing in the northern part of the county had to sever physician relationships at the beginning of the program more so than beneficiaries in the southern part of the county. Many of the beneficiaries in the north part of the county, prior to the Initiative, traveled to San Luis Obispo county to receive their care.

Under the Initiative, patients could not continue the relationships with physicians in that county. Hence, new patient-physician relationships had to be established in Santa Barbara. This trend accounts for some of the grievances which were filed because of dissatisfaction with the patients' initial selection of case manager.

Eligibility Category Medicare beneficiaries, who are also eligible for Medicaid, are the most dissatisfied of all categories of eligibles. They are more likely than other eligibles to have had a long-term relationship with their physicians, many of whom are specialists, who would not contract with the Authority to participate in the Initiative. Moreover, specialists cannot participate as case managers and, hence, direct access to their patients has been restricted. Yet some of the beneficiaries are referring themselves to providers who have not contracted with the Authority. The beneficiaries, who are being billed by the providers who are denied payment, submit complaints asserting they should not be billed for services.

A Grievance Review Committee, composed of providers, beneficiaries, beneficiary advocates, staff, and a member of the Board of Directors, has heard three grievances since the inception of the program. Of these three, two petitioned the Committee's decision to the State Fair Hearing Office.

C. Beneficiary Relations

The Authority has committed substantial resources to beneficiary relations. About 25 percent of the staff works in some way with beneficiaries. One small part of their activity includes the preparation of a beneficiary newsletter, in Spanish and English, which has been issued four times during the course of the Initiative. Topics covered include:

- o Child Health and Disability Prevention services
- o availability of beneficiary service representatives
- o beneficiary billings by providers
- o general health tips.

Chapter Six

Remaining Issues

The health initiative is designed to encourage Medi-Cal providers to serve patients in a cost-effective manner. Several issues have arisen which have implications for the success of the Initiative. The issues also may be relevant to other counties or states that are developing case management programs.

A. Quality Assurance

JBH has yet to produce a number of reports to enable the Authority to more adequately assess the effects of changed provider incentives on utilization. Also, while the Authority has developed a number of safeguards that assure oversight of the process of care giving, there has been little assessment of the effect of changed utilization on patient outcomes.

B. Cost Savings

As Medicaid expenditure increases are slowed by hospital contracting and limits on provider reimbursement, there is some question as to the cost-effectiveness of county-organized health systems. Some concern has been expressed that it may be hard to show substantial savings if the squeeze in the fee-for-service Medi-Cal program continues. At issue is whether the Authority can show that it is not just saving

program dollars but that the program dollars being spent are used more wisely without sacrificing, and perhaps enhancing, access and quality of care.

C. Patients Who Cannot Be Case Managed

The Initiative is the only demonstration that includes all Medicaid eligibles in its program, now that Monterey County has ceased its demonstration. It has found that some patients are difficult to case manage. For example, some patients are determined eligible for Medi-Cal after they incur high medical expenditures. These patients cannot be case managed. At issue is whether the Authority will continue rendering care to approximately 3,000 of these patients under a capitation payment system or whether the state will pay claims in full for these patients and remove or modify the Authority's risk.

D. Nature of the Competition

There appears to be little opportunity for providers to compete on the basis of price. Also, given that there is no open enrollment in the program, there is relatively little opportunity for patients to "walk with their feet." Yet many providers, particularly hospitals, are concerned about maintaining and increasing their share of Medi-Cal patients. The activity in the market that is now taking place is giving impetus to providers' concern about market share. This activity also explains the interest expressed by some members of the board

of directors to examine the feasibility of the Initiative enrolling Medicare beneficiaries.

E. Transition Options

The board of the Authority has been assessing the transition options for the Authority when it ceases to be a federal demonstration after June 30, 1986. The options include:

- o continuing as a demonstration project; this option would continue the project nature of the program and would not have it become a permanent part of Medi-Cal;
- o applying for a Section 1915 waiver project; this option would permit the program to remain intact structurally. The Authority would be required to negotiate a contract with the state's Medical Assistance Commission, following the example of the San Mateo and San Bernardino county programs which are in the development phase.
- o including all Medicare eligibles in Santa Barbara county in the Initiative.

The Authority has decided to develop a Section 1915 waiver request to HCFA to permit the project to continue after the demonstration waivers expire on June 30, 1986. The Authority has also decided that in whatever form the program continues, it does not intend to renew its contract with JBI which expires June 30, 1986.

F. Lessons Learned

- o Management Information System Data needs must be identified prior to the start of the program and continual monitoring of the data system contractor is necessary.

- o Utilization Controls Utilization controls, particularly prior authorization are crucial to the maintenance of a fiscally sound system. Also, centralized review of practices of participating providers is an important feature for utilization control and quality assurance.
- o Governing Board The board that governs the program needs to have good relations with local providers and key political actors in the community to lend credibility and support to the program. Also, support from key state legislators is crucial. Moreover, board members need to understand the workings of a capitated payment and contracting system.
- o Grievance Process A grievance procedure needs to be readily accessible to beneficiaries for it to have credibility, and to be useful in highlighting problems with the program.
- o Eligibility Information The Authority needs timely and accurate eligibility information for it to effectively administer the program. When the eligibility information comes from several different programs, such as AFDC and SSI, receiving timely information is often hampered.
- o Information for Case Managers Case managers need timely reports that document the patient's use of health care services and the financial status of the trust accounts. Without this information, physicians cannot be effective case managers in a medical or financial sense.
- o Political Support Political support at the county supervisor level and in the state legislature has been crucial for the implementation of the program.
- o Program Management The low rate of turnover of a competent and dedicated staff has allowed for continuity in good program management.

Appendix A

List of Interviewees

Matiana Grogan, RN
Visiting Nurses Association
of Santa Barbara

Lars Brun Anderson
Financial Director
Cottage Hospital

Leeba Lessin
CEO
California Preferred Providers, Inc.

Kenneth Wagner, MD
Case Manager and Board Member
SBHA

Steve Barron
Financial Officer
Marian Hospital

Elliot Shulman, MD
County Health Department

Katharine Humphries
Social Worker
Tri-Counties Regional Center
for the Developmentally Disabled

Victoria Connelly
Social Worker
Tri-Counties Regional Center
for the Developmentally Disabled

Sondra Davies
Executive Director
Santa Barbara Medical Society

Elizabeth Dovgin, RN
Utilization Review Supervisor
Cottage Hospital

John Beck
Deputy Director for External Affairs
California Department of Health Services

Sandy Pierce
Program Manager
California Department of Health Services

George Flores, MD
County Health Services

Bruce Howard, MD
Chairman, SBHA Board of Directors
and Specialist Physician

Joe Caves
Office of State Senator Hart

David Lamkin
Executive Director
SBHA

David Bearman, MD
Medical Director
SBHA

Steven Krivit
Director of Government Relations
SBHA

Kiyomi Bastian
Director of Provider Relations
SBHA

Marissa Villalon-Chapman
Grievance Coordinator
SBHA

Evaluation of Medicaid Competition Demonstrations

Volume III

The Monterey Special Health Care Authority

by

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American Enterprise Institute

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Preface

In September, 1983, the Office of Research and Demonstrations in the Health Care Financing Administration awarded a contract to a consortium headed by the Research Triangle Institute to evaluate seven Medicaid competition demonstrations in six states. As an important part of the evaluation, the American Enterprise Institute and Lewin and Associates, Inc. are performing annual case studies at each site over the four-year term of the demonstrations to trace their development.

This report presents the second and, as it turns out, the final case study of the demonstration in Monterey County, California, which was terminated on March 31, 1985. The evaluation team visited Monterey County just before the shutdown, and talked with all the staff members of the Monterey County Special Health Care Authority who were still in the area, as well as board members, providers, and others involved with the demonstration. The team also visited Sacramento, and spoke with state Department of Health Services staff who had been involved with the demonstration. This report tries to present these interviewees' various opinions as fully as possible, but offers the evaluators' own conclusions about the conceptual and operational reasons for the failure of the demonstration.

The evaluation team thanks all those interviewed for this study, especially Larry Zimmerman and his staff at the Authority and Sandra Carol Pierce of the Department of Health Services in Sacramento.

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CHAPTER ONE

Overview of the Demonstration

The Monterey County Special Health Care Authority administered the Medi-Cal program in Monterey County for nearly two years, from June 1983 until March 1985. The Authority contracted with the state to provide services to the Medi-Cal eligible population through the Monterey County Health Initiative, under enabling legislation passed by the state Assembly. The planning and initial implementation of the Initiative were described in the first case study report last year.

The Initiative's purpose was to test whether a case management model using primary care physician "gatekeepers" could control the rising cost of Medi-Cal services by limiting utilization, while maintaining the quality of care provided and even improving access to care. Unlike the demonstration in Santa Barbara County, however, the Monterey demonstration tried to make case management work without the incentives for provider cost-consciousness created by prepayment for their services.

Instead, the Monterey Initiative maintained fee-for-service payment to physicians and hospitals, with the promise of higher rates of payment if they succeeded in limiting utilization of health care services. Case management of each patient's care was expected to substitute less costly primary and ambulatory care for more expensive specialty and inpatient care where appropriate, and to reduce use of the emergency room for

routine care. As it turned out, these expectations were not met, and the Initiative was terminated a little more than a year before the planned end of the demonstration.

The Authority ended up being squeezed between the fixed capitation payments it received from the state to serve the Medi-Cal population and its own open-ended payment arrangements with providers. These arrangements not only lacked the incentive force of prepayment, but were more generous than the terms of payment available to providers under the regular Medi-Cal program.

The Authority was paid 95 percent of the projected fee-for-service costs of delivering Medi-Cal services to county eligibles. But given its overgenerous payments to providers, its own administrative costs, the already low rates of utilization of health care services in Monterey County (among the lowest counties in the state and well below Santa Barbara), and the lack of strict utilization controls until more than a year after it began operating -- the Initiative's financial downfall does not seem surprising in retrospect.

The Authority may seem to have assumed the risk in this demonstration, but the size of the cumulative deficit (estimated at more than \$6 million at the time of the shutdown) and the Authority's lack of any substantial assets has left providers assuming considerable risk after all -- because they will have to accept much less than full payment for many of their claims. For the largest Medi-Cal providers in Monterey County, the Initiative may have proved riskier than capitation might have been.

CHAPTER TWO

Monterey County and Medi-Cal

The Initiative served all Monterey County residents eligible for Medi-Cal, including both AFDC recipients and SSI eligibles. They were covered for all Medi-Cal services except dental care -- but including long-term care. Enrollment was about 26,000, compared with about 22,000 in Santa Barbara County.

Physician participation in Medi-Cal appeared to increase substantially -- from 114 primary care doctors before the Initiative to about 160 while it was operational (some of the case managers were specialists with just a few patients, and not primary care physicians as contemplated in the design of case management systems). The largest single case manager was a hospital -- Natividad Medical Center, which served more Medi-Cal patients than any of the other five hospitals in the county. All six hospitals contracted with the Authority to serve enrollees in the Initiative. Despite such provider participation, the uneven distribution of medical resources in the county -- clustered around Salinas, the largest city, and on the Monterey Peninsula -- left some concern about sufficient access for recipients in the less-served, more rural part of the county around King City (a fuller discussion of this can be found in the first-year case study report).

Changes in Medi-Cal. The state of California is pushing ahead with a policy of encouraging competition among providers of Medi-Cal services. The Department of Health Services is trying several approaches to doing this: county-organized health systems like Monterey and Santa Barbara; enrollment in prepaid health plans under the expanded choice program; hospital contracting by the state's Medical Assistance Commission for services in all areas other than those where beneficiaries are enrolled in county-organized health systems or prepaid plans.

State policymakers originally viewed hospital contracting as a temporary way to control the rate of increase in hospital inpatient expenditures -- the largest single component of total Medi-Cal spending -- until more beneficiaries could be brought under county systems or placed in prepaid plans. The county-organized model is being refined on the basis of experience in Monterey and Santa Barbara counties. It will be tried in two additional counties, San Mateo and San Bernardino, probably beginning early in 1986.

The expanded choice program is expected to enroll large numbers of beneficiaries in prepaid plans in six target areas. The Medical Assistance Commission is developing this initiative in parts of Los Angeles and San Diego counties soon, and could enroll up to 20 percent of all recipients under current state law and the terms of the waivers. Enrollment must be in federally or state-qualified HMOs, eleven of which have signed contracts with the state to serve Medi-Cal patients.

A state senator's proposal to enroll 60 percent of beneficiaries in prepaid plans by 1989 was defeated, partly because of disagreement over the timing of the move to capitation and away from fee-for-service payment. There is some concern that such ambitious goals could not be met without raising the spectre once again of the highly publicized abuses by some providers when a similar policy was tried a decade ago. The commitment to capitation for the Medi-Cal population seems to enjoy a consensus among state policymakers -- perhaps even reinforced by Monterey's failure with fee-for-service payment, but selective contracting also has gained widespread acceptance, and there may not be a rush to move any faster toward a capitated system.

CHAPTER THREE

Implementation Process and Outcome

A. Case Management and Utilization

The Monterey County Health Initiative was designed originally to control the utilization of services under the state Medi-Cal program through implementation of a case management system. Under this model, primary care physicians were to serve as case managers for Medi-Cal enrollees, with responsibility for providing all primary care and -- most important -- for authorizing all referral care and nonemergency hospitalization. This second point is critical to the success of a case management system, because the big cost savings come from reducing hospitalization and inappropriate use of more expensive services generally -- such as emergency rooms for routine care.

In order for case management to achieve this objective of bringing about more appropriate patterns of utilization, the case managers must have incentives to perform the case management function as well as tools to help them do it. The Santa Barbara Initiative built the incentive into its program design by putting case managers at some financial risk under a prepaid capitation scheme. The Monterey Initiative lacked this automatic incentive to control utilization because it retained the fee-for-service payment system -- making the tools for controlling utilization even more important. But for the entire first year of its

operation, the Initiative lacked the tools as well as the incentives. As a result, utilization was not controlled, and costs greatly exceeded the Authority's overall capitation from the state -- resulting in its bankruptcy.

No advocates of case management would argue that it can work without formal utilization controls to prevent self-referrals by patients. The case managers interviewed during the site visit agreed on the need for a formal mechanism to assure that case managers have authorized all referral care and nonemergency hospitalization beforehand. Without prior authorization checks on these procedures, case management will not control utilization -- as the well-chronicled and often-cited SAFECO experience in Seattle demonstrated several years ago.

The Initiative's original design did not incorporate such a formal prior authorization check, but depended on informal peer pressure and management information reports to control physicians' behavior. The inability to get timely or reliable management information will be discussed in a later section, but such reports -- even if timely and reliable -- give only a retrospective picture of experience. And peer pressure cannot substitute for a formal prior authorization system -- as was recognized in the state's request for proposal, which asserted that no claims would be paid without such a system in place.

The new chief executive officer of the Authority assumed office shortly after the Initiative became operational in June 1983, and saw almost immediately the need for more formalized utilization controls. With the arrival of a new, full-time medical director in November 1983, the first step in what proved to be a gradual phase-in was taken. Hospitals were required at least to call the case manager before treating anyone who arrived at the emergency room for nonemergency care; otherwise, they would not be paid. This procedure was implemented after there had been an increase in emergency room use during the early months of the Initiative; after its introduction a decline was noted in both the number and cost of emergency room visits.

Interestingly, one case manager instituted his own control on emergency room use by writing to enrollees who went there without calling him first, and threatening to drop them; he reported few second offenders. The same doctor stated that emergency room control was imposed as early as it was only because the physician case managers insisted on it as necessary if they were to be effective in managing care.

A prior authorization mechanism for hospital ambulatory services and same-day admissions was put into effect in June 1984. It required the case manager to provide either a copy of an authorization form or an authorization number over the phone. A copy of the form was sent also to the Authority's fiscal agent, Jurgovan and Blair (JBI), and the information entered in the case manager's computer authorization file. When the claim was submitted it was also entered in the computer and

matched against the authorization file; only if it matched was it to have been paid.

At the same time that the Authority initiated concurrent stay review of authorized hospital admissions, a nurse was hired to perform this selective function. She carried out some on-site reviews, although most of them were done over the phone. Despite the need for more and better information than was available from the management information system, the period from June through September of 1984 saw a 13 percent overall drop in inpatient days compared with the first year of the demonstration.

In September 1984 the Prior Authorization Tracking System (PATs) was extended to physician referrals and allied health services. Thus, more than a year after the Initiative became operational, specialists finally had to get a written authorization from a case manager before providing services. Case managers had the final say on the decisions they were authorized to make -- they could not be overruled by the specialists. This authority was not always exercised, though, because not all case managers were willing to contest the question of whether particular procedures were appropriate or necessary if challenged by a specialist.

The Authority was beginning to gain control of utilization, but it came too late -- and was too little in the face of the large deficit already incurred. The medical director attributed the delay in implementing centralized controls to three factors: (1) the reluctance

of providers to accept a more restrictive system after agreeing originally to a consensual one; (2) a lack of sufficient and timely data to identify actual utilization patterns; (3) the inability of the Authority's own board and staff to act sooner to "avoid another SAFECO."

The Authority tightened the program another notch in September 1984 when it required all nonemergency hospital admissions to be authorized by the medical director or by a physician reviewer. Urgent cases were handled by phone, but elective surgery had to be authorized in writing. Nurses at the Authority checked each case with the medical director or physician reviewer, and none of their decisions was appealed by any physician to the Authority's Professional Advisory Board.

There may be a lesson in the chronology of the inpatient admissions control mechanism. The Initiative operated for an entire year with no formal control at all, and physician case managers complained of the need for a formal prior authorization check. Such a requirement was finally implemented at the start of the second year in the form of the PATS, giving case managers the final say on most nonemergency admissions. Yet, three months later, the Authority took this responsibility upon itself -- apparently to the relief of most primary care physicians and even at the urging of many. Although some case managers welcomed the power to control utilization, in the end many of them preferred to have the Authority's medical director make such decisions.

Interestingly, the Santa Barbara Initiative was designed with centralized approval of nonemergency admissions. One of the Monterey Initiative's case managers argued that the proper way to design the system was to start with centralized controls on everyone, and then to loosen them only on those who performed well. This argument is given some plausibility by witnessing the results of starting with a loose system and then trying to tighten it. But it leaves two questions that are posed sharply in Monterey County and perhaps elsewhere as well: (1) Would physicians have accepted a centralized system at the start, given their initial lack of enthusiasm for the Initiative? (2) How many primary care case managers want to assume the full responsibility for controlling utilization and -- with this -- for confronting their patients and the specialists in their medical community?

B. State Rate Setting

The Authority received a capitation payment from the state to provide Medi-Cal services through the Initiative. This overall capitation was set at 95 percent of projected fee-for-service expenditures in the first year, but the manner in which it was calculated became a point of contention between the Authority and the state Department of Health Services (DHS).

The Authority's actuarial consultant for the second-year rates stated the issue this way: the original rate calculations were based on beneficiary aid categories, but rates for some categories -- where there was insufficient Monterey County experience -- were based on statewide experience adjusted for Monterey County. While this practice is itself defensible, the Authority argues that the adjustments made for some of these categories were not appropriate because they were based on Monterey County experience for very different categories. The obvious example would be AFDC recipients, a category for which the County's experience makes it one of the lowest-utilization areas in the state. To use this experience to calculate rates for SSI recipients or other more difficult-to-serve populations such as medically indigent children or pregnant women, could inappropriately lower the base for rate-setting purposes if Monterey County's utilization experience for these categories were not as far below the state average as its experience for AFDC recipients.

According to the Authority's chief executive officer, such inappropriate adjustments cost it perhaps as much as \$750,000 that it should have received in first-year capitation payments. The actuarial consultant argued further that the state made no effort to adjust the base for actual first-year Monterey program experience in computing the rates for the second year.

The state's actuary at DHS maintained that an effort was made to base the adjustments of statewide data for special categories on Monterey County categories for which sufficient data were available.

DHS also claimed that it calculated the rates using another methodology for estimating actual experience for the special categories in Monterey County, with substantially the same results. When it came time to adjust the rates for the second year, DHS argued that it never had audited data on Monterey's first-year experience under the Initiative to match up with the state's fee-for-service numbers.

The Authority did have an audit report done for the first year, but the board of directors refused to accept it because it failed to examine the integrity of the fiscal agent's claims reports. These reports were critical to assessing the Initiative's true financial status, which never was determinable from the information provided by Jurgovan and Blair. The state's position that it lacked audited data on the Initiative's first-year experience to use in making the second-year rate adjustments is, therefore, supported by the action of the Authority's own board in rejecting the outside audit report.

Administrative costs were another point of contention between the Authority and DHS. In the first year the state allowed $1\frac{1}{2}$ percent of the total capitation to be allocated to the Authority's own cost of administering the Initiative. With actual administrative costs running at 8 percent, it cost the Authority more than a million dollars above the state's allocation to operate the program. For the second year, the state proposed raising the administrative cost allowance to 2 percent -- still far short of the Authority's actual costs.

The state maintains that it can only pass along whatever part of its own costs are saved by having the Authority administer the Medi-Cal program in the county. Both Monterey and Santa Barbara counties contend that this is neither fair nor realistic -- as witnessed by the higher cost allowance of 3½ percent given to San Mateo County, which will be the site of the next capitated county-administered program. DHS responds that the terms for San Mateo and other future county-run programs are being negotiated by the California Medical Assistance Commission, a legislatively-created body that also does the contracting for Medi-Cal inpatient hospital care in the rest of the state.

The Authority's capitation payment from the state took into account a stop-loss limit of \$15,000 for each enrollee in the Initiative. The state set aside a separate reserve out of which it was to reimburse the Authority for any expenses incurred beyond this limit (except for long-term care, for which there was no stop loss). But the Authority complains that the state delayed many months in paying these claims, and this payment backlog contributed at least a million dollars to the deficit in the first year.

DHS admits that its actuarial projection of stop-loss recoveries was much too low, largely because it used the experience of prepaid health plans that serve chiefly AFDC recipients -- who tended to be healthier and less apt to incur major expenses than disabled or other special category recipients. This seems to have been an administrative

problem in Sacramento, where the sheer volume of such claims apparently overwhelmed the system (the Authority's consulting actuary figures that DHS expected fewer than 20 stop-loss claims based on the experience of prepaid health plans; instead, it got 250).

The experience with stop-loss claims reinforced the Authority's feeling that state actuarial projections generally were inaccurate. In the second year, when DHS projections were based on the large claims experience of the state's own Medi-Cal fiscal agent (Computer Sciences Corporation), the stop-loss limit was raised to \$25,000 -- unless the Authority was willing to accept a \$900,000 reduction in its capitation to keep the limit at \$15,000.

The Authority voiced its various concerns about the rate-setting process during discussions with DHS about the adjustments in the rates for the second year. The second operating year began in June 1984, but new rates were not proposed by the state until October -- and were finally accepted by the Authority in February 1985, under protest and after the Monterey County Board of Supervisors had voted to terminate the Initiative. A similar lag had occurred after changes were made in the state's Medi-Cal rates in August 1983. The Authority was not given proposed adjustments in its rates -- based on these changes -- until February 1984, and a rate amendment contract was not signed until more than a year after the state Medi-Cal changes were made. Under such

circumstances, the Authority argues that there was little it could do except agree to whatever the state offered -- since it had already incurred obligations to the providers who delivered the services.

During discussions about the second-year rates, the Authority asked DHS to raise the overall capitation payment from 95 percent of projected fee-for-service expenditures to 97.8 percent. The same request was made by the Santa Barbara Authority, reflecting the same concern that adjustments to the fee-for-service base brought about by expected cost savings in the regular Medi-Cal program -- for example, from selective hospital contracting -- would reduce the rates for the second year.

The state was sympathetic to this concern, and agreed to raise the percentage of expected fee-for-service expenditures as requested by both Monterey and Santa Barbara. But the Health Care Financing Administration (HCFA) refused to approve such an increase, because the terms of the federal demonstration grants called for a 95 percent of fee-for-service limit on the capitation.

The Authority's board of directors lost hope in December 1984 according to its chairman, when the second-year rates finally offered by the state did not contain the relief sought -- the increase to 97.8 percent of expected fee-for-service expenditures, more favorable actuarial assumptions regarding the special categories of eligibles for which statewide experience was adjusted by a Monterey County factor, and a substantial increase in the allowance for administrative costs. The board concluded that the Initiative could not be saved, and

recommended to the Monterey County Board of Supervisors that it be shut down within 180 days -- the notice required in the enabling legislation.

The supervisors voted unanimously at the end of January to dissolve the Initiative at the end of July, but further discussions with the state resulted in an agreement to terminate it at the end of February. All unpaid claims were then to be submitted within 60 days for settlement in May; the Authority, meanwhile, filed for relief in bankruptcy court in order to determine the pro-rata distribution of its assets to its more than 1000 creditors. The regular Medi-Cal program resumed operation in the county at the beginning of March, with Computer Sciences Corporation stepping back in as fiscal agent and running reorientation sessions for providers.

C. Payment of Providers

In the contracts the Initiative negotiated with participating providers, it continued to pay them on a fee-for-service basis, and on terms more generous than they would have received under Medi-Cal. Primary care case managers were paid a 10 percent premium above the current Medi-Cal Schedule of Maximum Allowances (SMA). In addition, they were given a three-dollar-a-month case management fee for each enrollee, both as an inducement to participate and as compensation for the administrative and other burden of acting as case managers -- such as having to authorize all referrals either in writing or by telephone.

The combination of paying higher fees than the SMA plus the case management fee amounted to rewarding physicians for performance before it was demonstrated. The case management fee in particular was criticized by several interviewees, including one of the supervisors who felt that physicians should have given it up entirely at the start of the second year -- after it cost about \$750,000 in the first year.

But the case managers interviewed all felt strongly that the fee was needed to get their participation, and that they earned it as case managers. One case manager stated that he had offered to drop the fee if HCFA would grant a waiver allowing collection of copayments of five dollars for office visits and ten dollars for emergency room visits. There were provisions for copayments of one dollar for office visits and five dollars for emergency room visits, but he said that physicians never collected the former and hospitals stopped collecting the latter. But HCFA did not grant the waiver, and the case managers ended up agreeing to cut the fee in half to \$1.50 per month for each enrollee in the second year. At the same time, they also gave up the 10 percent premium above the Medi-Cal SMA that they had been paid for their own services.

The design for the Initiative included financial incentives for more cost-effective practice. Case managers were assigned accounts credited with sums equal to their proportional shares of the total capitation paid to the Authority (determined on the basis of how many enrollees they had in each aid category). All payments for services

were debited against these accounts, as were the case management fees. Any surpluses at year-end were to be paid out as bonuses, not to exceed the difference between the Medi-Cal SMA and the physicians' usual, customary, and reasonable charges. As it turned out, the Initiative ended up with a large deficit, and the information system did not provide reliable figures on individual physician accounts.

Hospital contracts with the Authority were criticized by many interviewees as "too rich." The Monterey County Board of Supervisors was especially concerned about the impact of the Initiative on the county hospital, Natividad Medical Center. This concern influenced the terms of the contract with Natividad, which called for it to receive 100 percent of its billed charges. The other five hospitals in the county signed contracts for 97 percent of charges, with a 5 percent withhold that was to be distributed later depending on their performance. Natividad was also the largest case manager under the Initiative, for which it was also paid 100 percent of charges -- but not the case management fee.

Natividad's administrator pointed out that the hospital was already paid 96 percent of billed charges under Medi-Cal interim rates while other hospitals were receiving 90 percent, because its charges were not much more than its costs. He felt that giving up the case management fee was worth the extra 4 percent, so that the hospital was not being given special treatment after all.

Natividad was getting an additional 4 percent above Medi-Cal interim rates in its role as a hospital, though, even if it was not in its role as a case manager. The other hospitals were getting a premium as well, and the value of the premium was probably greater than indicated by comparison with Medi-Cal interim rates because those rates would almost certainly have been lower if the county had been under the state's selective hospital contracting program.

Hospitals also agreed to a reduction in their payment rates for the second year -- to the Medi-Cal interim rates they had been receiving before the demonstration. As it worked out, however, they received less than those interim rates in real terms because the Initiative did not adjust the rates by an inflation factor. As a case manager, though, Natividad did start to receive the reduced \$1.50 per month case management fee for its enrollees.

Skilled nursing and intermediate care facilities were paid directly by the Authority at 100 percent of their per diems for providing long-term care to enrollees. Certain providers such as podiatrists, optometrists, and chiropractors -- who were outside the case management system but included in the Initiative -- were paid at prevailing fee-for-service rates under contracts with the Authority. A physician who was on the board complained that there were too many of these "exceptions," which diminished the impact of case management on total utilization of services.

D. Financial Status of the Demonstration

The Monterey Initiative was shut down because it had become financially unviable.. The deficit was at least \$3 million in the first year, and had climbed to about twice that sum by the time the decision was made to cease operations (the Authority's consulting actuary estimated the total deficit to be about \$5.5 million, while the state's actuaries put it at about \$6.75 million; the difference is accounted for by disputed items discussed below.

The Authority received total capitation payments of \$25 million from the state in the first year, plus -- eventually -- another \$2 million for stop-loss claims that exceeded the \$15,000 excess liability provision of the contract. This stop-loss money was an irritant to relations between the Initiative and the Department of Health Services during the first year. As mentioned in the rate-setting section, there were considerable delays in getting it; at the time of the first case study report the Authority claimed that it was still owed \$1.1 million. While it was eventually reimbursed for these excess liability claims, the payment lag compounded an already-serious cash flow problem for the Initiative.

The difference of about \$1.25 million between the Authority's and DHS's estimates of the total deficit comes chiefly from a dispute over unpaid pending claims. The Authority argues that it was underpaid

by more than a million dollars because of problems with the state's Medicaid Eligibility Determination System (MEDS). The Department of Health Services responds that these claims were not documented, and that the problem lies within the Initiative's own claims processing system.

The difference will have to be reconciled during bankruptcy proceedings in order to close the Initiative's books. The Authority received its monthly capitation payments off the state's Eligibility History File (EHF) rather than the MEDS. Presumably, the discrepancies can be found by matching these two files. The Authority's chief executive officer said he had been trying to obtain the EHF for more than a year to do a month-by-month comparison with the MEDS tapes that are supplied to its fiscal agent, Jurgovan and Blair. Without access to the EHF, weeks of analysis may be needed to identify examples of discrepancies.

The other major point of dispute affecting the size of the deficit concerns payment for long-term-care. The Authority claims that the DHS miscalculated the long-term-care rates by mistakenly averaging some long-term-care days in with acute-care days at Natividad -- paying for them at 95 percent of expected fee-for-service expenditures instead of 100 percent. The state's actuary agreed that some long-term-care costs had been counted as acute-care costs by mistake and included within the 95 percent capitation, but still found that the Initiative had been paid enough for long-term care.

The Monterey Initiative faced some ineluctable arithmetic from the start. Beginning with a total capitation from the state that was five percentage points below projected fee-for-service spending, it then had to cover administrative costs of 8 percent when DHS allowed only one percent of the capitation for this purpose. This amounted to a difference of more than a million dollars. And it then had to pay case management fees that cost \$750,000. This put it about \$2 million behind before it started paying for delivery of services -- reducing the effective capitation for service delivery to about 87 percent of the fee-for-service base, which the Authority believes was artificially low because of inappropriate adjustments discussed earlier in the rate-setting section. And finally, it had signed contracts agreeing to pay both case managers and hospitals at rates higher than they would have received under Medi-Cal. These amounted, as one board member put it, to "paying more than Medi-Cal while trying to spend less!"

Under these circumstances, it would have required a very large reduction in inpatient utilization to have a chance of breaking even. Yet, the Authority's original consulting actuaries' report reported that it could be done with a 7 percent drop (one interviewee recalled that the original planning documents called for reducing utilization by 25 percent, but the evaluation team could not find written evidence of this).

As it turned out, utilization actually rose in the first year -- producing a large deficit that no one could cover. One DHS official told us that the state would have been willing to make some changes in the Initiative -- such as taking some of the most difficult-to-manage categories of recipients back under the fee-for-service Medi-Cal program -- but that it could not deal with the overhanging deficit from the first year.

Several of the Authority's board members felt that the state effectively withdrew its support from the Initiative when it failed to offer either a loan to cover the first-year deficit or better rates for the second year. The state assemblyman from Monterey County who sponsored the legislation that first established the Special Health Care Authority has introduced a bill calling for legislative relief in the form of a loan, but it seems unlikely to pass. One of the county supervisors felt strongly that once the state approved the design of the Initiative, it should have been willing to help with the deficit. But the supervisor -- who was one of two who voted against the demonstration in the first place -- also asserted that the state should never have approved the design to start with.

As it is, the providers are left with substantial unpaid claims. The hospitals are owed the most; Natividad's administrator figures it is owed at least \$2.5 million, and expects to get about 20 cents on the dollar out of the bankruptcy court settlement. Two of the largest physician case managers are both owed \$50,000, and expect to receive 15 to 25 cents on the dollar. There were rumors of a possible lawsuit

against the state for monies owed to the Initiative; it would presumably join the hospitals, the medical society, and the county as plaintiffs, but the legal basis for such a claim is unclear.

E. Quality Assurance and Utilization Review

The Authority's medical director submitted quality assurance and utilization review draft plans to the state DHS in May 1984. This was nearly the end of the first year of operation, and a month before concurrent stay hospital review was implemented as the first formal component of the utilization review system. As far as can be determined, no formal approval of the QA/UR plans was ever given, and because of information system and other problems they were never fully implemented.

The medical director had responsibility for quality assurance. The quality assurance subcommittee of the Professional Advisory Board (PAB) was to serve a peer review function, to complement the medical director's role. But according to the chairman of the PAB, a specialist who also served on the Authority's board, this subcommittee never got involved in the quality assurance process because of the lack of necessary data. He stated that no formal quality checks were made, and the Authority's chief executive officer confirmed that the quality assurance program was only partly implemented for lack of reports from Jurgovan and Blair (JBI); only ad hoc reports were ever received, which were unreliable. The quality assurance data module was never received -- although JBI had provided a detailed system design and begun producing some interim reports at the time of the first case study report.

The original chairman of the Community Advisory Board (CAB) -- who also sat on the board of the Authority -- expressed the opinion that the quality of care delivered to Medi-Cal recipients had improved under the Initiative. He felt that beneficiaries had more access to care than before because of the increased number of participating physicians and the case management system that assigned them to their own doctors. And he also felt that they were getting better treatment, in part because they had some place to go with their problems and could get continuous instead of just episodic care.

These views were supported by his successor as CAB chairman, by the chairman of the Authority's board, and even by the county supervisor who voted against the Initiative. They all felt that improved access to care was the Initiative's greatest success, and that the quality of care delivered was at least as good as under the regular Medi-Cal program.

This view was supported by the absence of a single formal grievance during the program's duration. The Initiative's plan representatives were able to deal with every beneficiary complaint -- none reached the level of the joint PAB/CAB grievance committee -- largely because they were not adversarial in nature, but had to do mostly with changing case managers for reasons less serious than dissatisfaction with the quality

of care received. It appears that the Initiative helped new Medi-Cal eligibles get into the system who might not have done so otherwise. This may prove more difficult now, as many physicians refuse to take new Medi-Cal patients -- continuing to serve only those they are serving already. One case manager who was participating in Medi-Cal before the Initiative and served 700 enrollees at one point is no longer participating at all except for serving 150 Medicare crossovers.

While quality of care may be difficult to assess, a basic first measure is access to services -- which may be declining already as Monterey County goes back under Medi-Cal. The mistrust of the state expressed by several physicians as well as by county officials and board members may prove the bitterest result of the demonstration, especially if it cancels the one apparent gain made under the Initiative.

F. Management Information System

The Authority's fiscal agent, Jurgovan and Blair (JBI), was criticized by many of the interviewees for failing to produce the management information reports needed to run the program. The first year's case study report described problems with both the claims processing and management information systems, which hampered the Initiative from the outset. These problems continued in the second year.

Two case managers said the software package was never refined to the point where the program could find out where it actually stood at a given moment; the information provided by the reports was never timely because the problem of the lag on incurred but unreported claims was never solved. They also complained that the reports were never reliable, and were "more confusing than helpful because the columns never added up or matched." The one report considered useful was the list of recipients, but the various summary sheets were not used. Initiative staff seconded the opinions that the monthly case manager account summary was "worthless" as a management tool; it was taken from claims records, but from the month of payment report and not from the month of service.

One interviewee felt that JBI should have known that it could not get the software designed and "debugged" within the few months available from being awarded the contract in February 1983 to going operational in June. A board member had very early expressed a concern that JBI had "low-balled" its bid to get the contract. While the bid was only \$2 million compared with a \$4 million bid submitted by Blue Shield and Electronic Data Systems (EDS), the state's fiscal agent for Medi-Cal -- Computer Sciences Corporation (CSC) -- also submitted a \$2 million bid. But CSC had the considerable advantages of great familiarity with the Medi-Cal system and greater resources than JBI.

The Authority's chief executive officer -- who was not part of the original group that planned and started the Initiative -- felt that JBI lacked the resources to develop the system in four months, but was "hungry" enough to try. JBI bore the costs itself until it began to receive payments under the contract, because there was no money available from the state for system development. While CSC or EDS might have been able to do it in four months if they had been willing to put up some of their own capital, JBI needed longer with its more limited staff and computer resources. The Authority's chief executive officer felt it would have taken them at least eight months and perhaps a year.

As it turned out, JBI was still developing the software while trying to operate the system at the same time. As the months passed and the deadlines for various reports were missed, the Authority's board of directors put JBI on notice of intent to terminate its contract. JBI brought on a new project manager, but Initiative staff felt that JBI local programmers lacked the financial background and conceptual understanding of the health care system to design appropriate software. JBI's previous experience had been with HMOs, which have strong centralized controls on utilization. It lacked experience with a fee-for-service system like Monterey's, and had difficulty adapting its own model to the very different design of the Initiative -- which, originally, had no centralized controls at all.

When asked why the Initiative continued to put up with JBI as the months passed and the reports were either not forthcoming or were filled with errors that made them useless, the chief executive officer's response was that "at that point there was nothing else available." It would have been difficult to bring someone else in once the Initiative had gone operational -- if someone else could have been found.

As the first-year report noted, JBI does not feel that it was entirely to blame for the problems cited -- especially for the claims processing lag, which it blames largely on the state's new Medicaid Eligibility Determination System (MEDS). Late eligibility determinations caused delays in the final count, and erroneous omissions from the list caused claims to pend for months while eligibility was checked. In the previous section on the demonstration's financial status, there was discussion of the need to reconcile the MEDS list with the Eligibility History File (EHF) that determines the amount of the Authority's monthly capitation; until this is done, disputes with the state over many unpaid claims will not be resolved. JBI also blames the absence of a full-time medical director at the Initiative until October 1983 for part of the initial backlog of claims.

However the final shares of responsibility are apportioned, reliable information on how the case managers were performing was not available from the individual physician account reports. Whatever the problems with the state eligibility determination process, JBI was unable to get all the errors out of its system to produce dependable management reports.

The Santa Barbara Initiative has had some of the same problems with JBI, and has just decided not to renew their contract when it expires next June.

CHAPTER FOUR

Provider Behavior and Attitudes

Monterey County physicians generally were never enthusiastic supporters of the Initiative, but enough primary care case managers signed up to improve overall access for Medi-Cal eligibles. The Authority negotiated contracts with about 160 physicians, 60 of whom were specialists serving as case managers; this represented about a 40 percent increase in the number of "primary care" doctors who would see Medi-Cal patients.

Those who signed up hoped that local administration of the Medi-Cal program would be an improvement over increasingly onerous state control. They were also offered higher fees than Medi-Cal's Standard Reimbursement Allowance (SMA), and -- as one physician put it -- the additional "bribe" of the \$3.00/month case management fee. The decision to pay this fee before case managers had shown they could case-manage was criticized by many, but physicians were nearly unanimous in agreeing that without it they would not have participated. The case managers interviewed felt strongly that they earned the fee by having to deal with all the administrative burden of being case managers -- all the "phone calls and counseling" as one put it.

Once the Initiative became operational, a "limited, qualified support" of it developed according to the head of the Professional Advisory Board, despite 60 to 90-day delays in payment. But this

support became more tenuous as the financial situation worsened (or, perhaps more accurately, as the full extent of the financial situation became clear -- since the failure of the MIS to show claims incurred but not reported had led everyone to believe that the program was succeeding until the deluge of backed-up claims hit in May 1984, and the Authority suddenly found itself unable to meet its obligations). The Authority declared a 30-day moratorium on payment in June 1984, the case management fee was cut in half to \$1.50/month for each enrollee, and fees were reduced to the Medi-Cal SMA. At this point, some of the primary care case managers left the Initiative, but the larger ones returned; only a few small ones withdrew permanently.

Shortly after these events, the county medical society surveyed its 300 or so members and received responses from about half -- from 60 primary care case managers with enrollees and 90 specialists who accepted referrals. About 43 percent of the case managers wanted to return to the state Medi-Cal system, while 35 percent still supported the Initiative, about 17 percent were uncertain, and a few did not care. Specialists were divided very differently: about 63 percent preferred the state Medi-Cal system, while 24 percent were uncertain and only 9 percent still supported the Initiative. This difference is not surprising, since specialists were more opposed to the Initiative from the start.

One case manager expressed the opinion that case managers generally were happy with the program. And the chairman of the Authority's board conducted her own informal survey, which found half of the case managers still favoring the Initiative and half favoring a return to state control.

Natividad Medical Center was the largest case manager. Its enrollment target was 7700, but this was never reached. Actual enrollment reached 5800 according to the Authority, but Natividad's administrator put it at 4600. Whatever the precise number, case management was not likely to work unless it worked at Natividad -- and it was difficult to make it work there from the start.

The medical staff at Natividad was opposed to the Initiative from the start -- in part because of mistrust of the originators -- and felt that it was already practicing case management. The staff was salaried, and had no incentives to increase utilization; indeed, the average length-of-stay (LOS) was below that at other hospitals in the county. Other physicians attributed the shorter LOS to the family practice residents, but still felt that Natividad's physicians resisted the Initiative's controls and did not case-manage.

Natividad's administrator felt that the residency program could not be redesigned to implement the individual-physician-as-case-manager concept, which meant that enrollees were assigned by the Initiative to Natividad -- which then tried to assign them to the family practice, to

the medical director, or to the emergency room. The administrator told the Initiative that he needed help in assigning enrollees to individual physicians, but this concept was never fully implemented.

The head of the family practice clinic argued that Natividad was the only case manager in the system because of its built-in disincentives to overutilize. He said that enrollees were assigned to one of 22 individual physicians in the family practice clinic (which had about half of Natividad's total enrollment) and that the family practice residency program already put a premium on continuity of care. He also felt that most general clinic physicians at Natividad were familiar with case management because they were graduates of the family residency program. But he acknowledged that these doctors were not at the hospital every day to manage enrollees' care on a continuous basis. And he agreed that special clinic physicians were less familiar with case management -- although they were assigned only about 10 percent of Natividad's enrollees.

The dispute over Natividad's role as case manager will probably never be settled. Many physicians resented what they felt was a "sweetheart" deal under which Natividad received 100 percent of charges, seeing it as a subsidy to the residency program there. Natividad responds that it did not receive the \$3 monthly case management fee like the others. And as case manager of last resort for enrollees who did not choose other case managers, it ended up with a heavier share of more expensive aid categories -- as well as difficult enrollees who were dropped by others because they would not follow the rules.

It may be that, with a small number of notable exceptions, very few case managers practiced case management -- in part because they never clearly understood what they were supposed to be doing differently from what they were doing already. The strong feeling of the family practice physicians at Natividad that they were already case-managing before the Initiative ever existed points up the problem. The Authority's chief executive expressed the view that primary care physicians did not change their practice styles in response to the Initiative (although he feels that specialists became less willing to accept self-referrals when written prior authorization was required). The decline in inpatient utilization he attributes to the Centralized Hospital Admissions Program, which put the onus for admissions decisions on the Authority's medical director.

It is possible that more training or orientation for primary care physicians would have improved the process of case management. In the rush to sign providers up and get the program going, not enough attention was paid to telling them what they were supposed to do -- how their practice style should change under case management. Without sufficient knowledge of what to do, and without centralized controls to help make them do it or reports to determine whether they were doing it, the lack of behavioral change on the part of physicians may not be surprising.

But a harder question is raised by what happened after centralized controls were finally implemented. The case managers -- with those few notable exceptions -- decided that they "could not say no to their own patients" as a county supervisor put it, and gave their responsibilities for hard decisions to the Initiative's medical director.

CHAPTER FIVE
Consumer Satisfaction

As the first-year case study report noted, there were no attempts by consumer groups to block or challenge the Initiative, as occurred in some other states. And, as mentioned in the discussion of quality assurance in Chapter III, there seemed to be widespread agreement among providers, Initiative staff, board members, and consumer advocates that no major access or quality of care problems occurred while the Initiative was operating. Moreover, it is likely that access was improved, and that some recipients benefited from the continuity of care provided by their case managers. Yet, while consumers may have been net "winners" as a group under the Initiative -- and may stand to lose the most from returning to the state-run system, the Initiative failed to gain widespread community support according to the second chairman of the Community Advisory Board (CAB).

The CAB itself could have been a vehicle for building such support, made up as it was of representatives of organized community groups such as the area agency on aging, of beneficiaries, and of the community at large. But according to the CAB's first chairman, the beneficiary members did not play an active role on the board. He expressed the opinion that the CAB itself failed to have any substantial effect on the operation of the Initiative -- in part because of constant turnover that left only 3 of the original 15 members still on the board when the Initiative was dissolved.

Together with the Professional Advisory Board (PAB), the CAB drafted a three-tiered beneficiary grievance procedure consisting of an incident report, an informal grievance, and -- finally -- a formal grievance. The formal grievance procedure was to be followed when problems could not be resolved by the Initiative staff. Final responsibility for grievance resolution lay with the Initiative's board of directors, but -- as noted before -- no formal grievances ever reached the joint CAB/PAB grievance committee. In fact, there were only 2 informal grievances in 1984, which were settled by the Initiative's grievance coordinator.

There were 383 individual complaints filed during 1984, representing 224 incident/complaint reports and the 2 informal grievances. These complaints broke down into six categories:

<u>Category</u>	<u>Number</u>	<u>Percentage</u>
Accessibility	47	12.3
Acceptability	41	10.7
Quality of Care	117	30.6
Enrollment	31	8.1
Reimbursement	130	33.9
Other	<u>17</u>	<u>4.4</u>
	383	100.0

The most frequent accessibility issues were lack of emergency coverage, and inability to get an appointment when desired -- chiefly because the case manager was unavailable. The most common acceptability issue concerned a "poor attitude" on the part of the provider's office staff -- generally meaning that they either did not understand the Initiative or made little or no effort to help the enrollee to deal with its requirements.

Quality of care issues were the second largest category. The most frequent involved disagreements with or failures to understand the provider's diagnosis or treatment plan. There were also many requests for disenrollment, by providers as well as beneficiaries. Providers' requests were for such reasons as too many missed appointments or failure to follow physicians' orders.

Beneficiaries' requests were for several reasons: desire to choose a case manager after being auto-assigned, or because of computer error or failure to get their provider of choice; moved to a different location; just preferred a new case manager without giving a reason. Of course, not all requests for different case managers involved filing incident reports; many changes were made under rules established for such purpose.

The most common enrollment issues involved eligibility -- either when it was not approved for the date of service and had to be established retroactively, or when the beneficiary was eligible at the

time of service but was billed by the provider anyway. Complaints in the "other" category concerned the paperwork involved for providers to be paid by the Initiative, claims that billed services were not rendered, and protests that special eligibility cards were not received from the Initiative on time.

The largest category of complaints concerned reimbursement issues. The most frequent involved cases of providers billing beneficiaries instead of the Initiative because evidence of coverage was not clear. In other instances beneficiaries had paid for certain services for which providers did not bill the Initiative, either because they routinely had not billed Medi-Cal or would be reimbursed by the Initiative at less than the private pay rate charged the beneficiary.

The CAB's health education committee distributed a monthly newsletter to beneficiaries, emphasizing preventive care and reminding them how to use the case management system properly. The committee also worked with the health education coordinator at the Initiative, who trained the plan representatives to educate beneficiaries as they were enrolled and when they called with questions. Monthly forums were also held at several locations around the county, with primary care physicians making presentations to beneficiaries. These forums reflected the Initiative's conviction that physicians were ultimately the best educators of patients.

Consumer interests were well protected by the Authority's own board of directors, which was considered "anti-provider" and "pro-consumer" by several interviewees. Appointed by the county supervisors, many of the board members had served on the board of either the county hospital or the local Health Systems Agency. And the supervisors themselves showed great concern for the financial well-being of Natividad -- the county's most important Medi-Cal provider -- and for the access of rural and elderly recipients. In light of this concern, it is worth repeating that the most vigilant county supervisor felt access had been increased and quality had not been diminished by the Initiative.

CHAPTER SIX

Task Force Recommendations

When its serious financial condition became apparent in May 1984, the Authority took immediate steps to try to stem the deficit and keep paying providers. Surgeons' fees were reduced by 10 percent, to below Medi-Cal rates. Case managers were cut back by eliminating the 10 percent premium they had been receiving above the Medi-Cal SMA and by cutting their case management fee in half. Hospital rates were renegotiated down to interim Medi-Cal levels (actually below, because no inflation factor was added). The drug formulary -- which had been more inclusive than the Medi-Cal formulary -- was revised. And a list of surgical procedures was compiled for which the medical director's approval was required.

The Authority expected these steps to save more than a million dollars in the second year, with comparable savings expected from the utilization controls that were to be implemented. But this was not considered sufficient to put the Initiative on a sound operating basis, and a special task force was appointed by the board in June to recommend more drastic measures.

The task force was comprised of the board chairman, a county supervisor, the administrator of Natividad, and five physicians -- three primary care case managers and two specialists. The members recognized that only a major redesign of the program would give the Initiative a chance to operate without deficits in the future. The basic decision

was made to move to a capitation system for the AFDC population -- the largest, most stable and most predictable group -- but not for the smaller, less stable and less predictable groups -- and not for long-term care. Natividad was to be put on full capitation for all physician and hospital services for the capitated groups. Other case managers were to be put on partial capitation for physician services -- except for those with fewer than 100 beneficiaries, who would remain on fee-for-service. The other hospitals were to be paid per diems for inpatient care.

The overall purpose of the task force's recommendations was to put physicians at risk to the extent of their ability -- and willingness -- to accept that risk. Several of those interviewed expressed the hope that the risk structure would discourage those physicians with few enrollees from participating -- leaving a smaller number of case managers with a greater interest in making the system work. This approach was at odds politically with the "mainstream" approach of increasing access to the system by bringing more physicians into it. But it recognized the reality that 20 percent of the case managers had 60-70 percent of the beneficiaries.

Three beneficiary groups were determined to be suitable for capitation because their expenses were at least somewhat predictable -- families on public assistance, disabled beneficiaries on public assistance, and medically needy families not paying any share of the costs. These groups totaled 83 percent of all beneficiaries and

accounted for 67 percent of all program expenditures -- 80 percent if long-term-care facility expenditures were excluded. Natividad would have been fully capitated to provide all physician and hospital services to about 4000 beneficiaries in these three aid categories, at rates derived from those paid to the Initiative by the state but reduced for administrative costs and some contribution to general reserves (and adjusted for age and sex within each category).

Case managers with 400 or more beneficiaries would have received a partial capitation allocation to cover primary care physician services at a rate equal to 110 percent of Medi-Cal's Schedule of Maximum Allowances (SMA). This is the rate they received during the first year under fee-for-service reimbursement, before it was cut back to 100 percent of SMA as one of the interim financial steps discussed earlier. There was to be a 15 percent withhold, applicable to any deficit in an established target fund for inpatient surgery and hospital services and other outpatient services for the case manager's own group of beneficiaries. After any such distributions were made, case managers would have received all funds remaining in their withhold accounts. This design dealt directly with the lack of individual incentives inherent in the original fee-for-service program, which pooled all case managers' deficits and surpluses.

Case managers with 100 to 399 beneficiaries were to receive a capitation allocation equal to 105 percent of the SMA to cover primary care services, with a 10 percent withhold. The Initiative expected that these two groups of case managers -- all those with 100 or more

enrollees -- would be responsible for 90 percent of all beneficiaries in the three aid categories described. The remaining case managers for these aid categories -- as well as all case managers for the groups not being capitated -- would have been paid on a fee-for-service basis at 103 percent of the SMA, with an 8 percent withhold pooled to account for deficits in a targeted fund for inpatient and other services.

Specialists and allied health professionals were to be paid SMA rates, with 5 or 10 percent withholds on inpatient surgery. Thus, surgeons would have been put at risk for deficits in the targeted inpatient services fund for all beneficiaries -- a step that no other HCFA competition demonstration has taken.

The Initiative's medical director would have served as case manager for several aid categories with less predictable expenses, less stable eligibility, or specialized health care needs. These categories were long-term-care non-grant beneficiaries, medically indigent pregnant women, medically needy disabled beneficiaries, and beneficiaries residing outside the county -- such as foster children.

The long-term-care non-grant beneficiaries comprised only 2 percent of all enrollees, but accounted for 20 percent of expenditures. The Initiative's long-term-care nurse was to facilitate placements into and discharges from SNFs (skilled nursing facilities) for this difficult-to-case-manage population. Services provided to beneficiaries assigned to the medical director were to be paid at Medi-Cal's SMA.

Hospitals other than Natividad were to be paid at negotiated per diem rates. For the three major local hospitals, rates were to be developed for medical, surgical, and obstetrics services. Because of limited experience at the other hospitals, only two rates were to be developed -- obstetrics, and general. Natividad's uncapitated beneficiaries were also to be paid for at negotiated per diems.

A separate long-term-care task force was to be established to analyze the issues involved in developing differentiated rates based on the intensity of care required by beneficiaries. Under this scheme, higher payments would have been made to SNFs on a short-term basis when higher levels of care were needed. The long-term-care task force was to come up with recommendations that could be implemented in the third year of the demonstration.

The special task force's recommendations were accepted by the Authority's board in September 1984, and forwarded to the state. But no response was received, and as it became clear in the next few months that the Initiative could not be kept operating, the proposals were never seriously discussed. If the capitation scheme had been implemented, it -- together with the centralized controls already put in place-- might have made the program financially viable in the second year, if additional funds could have been made available to meet the first-year deficit. The question remains whether Monterey County physicians would have accepted capitation after being opposed to it earlier. Those case managers who wanted to keep the Initiative going probably would have agreed to it, but many case managers with few patients would have dropped out.

CHAPTER SEVEN

Conclusions

A. Design Flaws

The recommendation of the special task force to move to a partially capitated system and to put providers at varying degrees of risk can be viewed as an admission that the lack of capitation in the first place was a flaw in the design of the Initiative. The first case study report a year ago mentioned that the Initiative's originators wanted to introduce a prepaid system in place of fee-for-service reimbursement, but abandoned the idea when it was opposed strongly by local physicians. The physician member of the Authority's board did not recall prepayment being mentioned at all. But if it had been, he felt that doctors would have refused to accept it -- in part because they would have been against anything favored by the county health director who conceived of the Initiative.

Whether a case management scheme like the Monterey Initiative can succeed without putting the case managers at risk -- as they are in Santa Barbara -- may be debatable. But it seems beyond debate that such a scheme must have strict utilization controls if it lacks the built-in control of a fixed capitation payment. More specifically,

there must be a mechanism for assuring that primary care case managers have authorized all referral care before it is given. Such a prior authorization check was missing from the original design of the Initiative, which relied on informal peer pressure to control physicians' behavior. The new management team realized that this was not working, but it was not until early in the second year of operations that a formal mechanism was put in place to fill this large gap in the system.

The payment design was flawed by the original decision to pay case managers, specialists, and hospitals at higher rates than they would have been paid under Medi-Cal. This could have worked only if utilization had been reduced drastically, but with the failure to include strong utilization controls in the original system design utilization actually increased. The Authority realized that the payment terms were too generous, and moved to cut back the rates to Medi-Cal levels or lower at the start of the second year. But like the introduction of a prior authorization check, it proved to be too late in the face of the large deficit already incurred.

The make-up of the Authority's board may have been a problem as well. It was perceived by the medical community as being anti-physician, while at the same time lacking sufficient business expertise to understand and work to correct the Initiative's operating and financial problems before they had become insurmountable. And it lacked, also, the presence of a county supervisor as in Santa Barbara to provide visible political support for the demonstration. The two physician members of the board felt themselves to be a distinct

minority, whereas in Santa Barbara a physician serves as chairman of the board. Of course, the board may have represented accurately a lack of physician and supervisor commitment to making the Initiative work, a commitment that has seemed much stronger in Santa Barbara from the start.

Perhaps the greatest flaw in the overall design was the assumption that a big cut in utilization could be achieved in a county where it was already low compared with most of the state. If there was little excess utilization to get rid of, the arithmetic of the demonstration -- delivering care for 95 percent of the fee-for-service cost -- may have assured its failure at the outset, even if the other flaws had been corrected.

B. Operational Failings

The Initiative's design faults may have been sufficient in themselves to cause its failure, but they were compounded further by a series of major operating problems. The most immediate problem involved personnel: there was almost a complete turnover of staff within six months of start-up, and several key positions went unfilled for many months. The new chief executive officer had just taken over permanently at the time of the first site visit in January 1984. The first full-time medical director had been there for only a short time, and it was several months later before a financial officer was hired -- and he had left well before the second site visit in March 1985.

The combination of turnover and vacancies would have made things difficult even if the new staff had only to familiarize itself with a fully-operating system. But the Initiative's staff had to redesign parts of the system and create other parts while trying to keep it operating. As a result, it was constantly trying to catch up -- with claims backlogs, overdue reports to the DHS in Sacramento, and implementation of various pieces of the control system. For example, it was many months after the need for a formal prior authorization check was recognized before one was finally put into place.

Problems in the Initiative's working relations with the DHS were never resolved satisfactorily. The delays and errors in the state's verification of recipients' eligibility continued to hold up payments that were needed to reimburse providers for services already rendered. As a result, many claims were left pending for months, causing provider dissatisfaction and undermining their support for the Initiative. Of course, the DHS blamed some of the delay on the Initiative's inability to document claims properly because of failings in its own claims processing system.

One of the most troublesome issues was the protracted delay in getting payment from the state for the so-called "15K" claims -- those which exceeded the \$15,000 stop-loss limit on the Authority's liability and were to be reinsured by the state. The long payment lag while the DHS tried to deal with the unexpectedly large number of such claims compounded the Initiative's cash flow problems.

Delays were also experienced in getting the state to adjust payment rates for the second year, as they had occurred in adjusting the first-year rates when the state's Medi-Cal rates were changed early in that year. The Initiative objected also to the state's unwillingness to use the demonstration's actual first-year experience in calculating rate adjustments for the second year. But the DHS never received an audited financial report of the first year's experience.

The Initiative's difficulties with its claims processing system were one aspect of what was probably the most serious operational failing of all -- the inability of the fiscal intermediary to get the various computer-based data systems operating correctly within a reasonable time. This was the case with the management information system as well as the quality assurance and utilization review systems.

The Initiative was unaware of the seriousness of its financial situation until suddenly finding itself unable to pay providers in the spring of 1984 -- when it was overwhelmed with claims that had been pending for eligibility checks. Only then did it become apparent that something was seriously wrong with the claims processing system -- nearly a year into the demonstration.

It also became apparent that the reports being given to physician case managers were of little use for management purposes. Lack of reliable or meaningful information on their financial status and, hence, on their performance in managing recipients' care made case management infeasible. Physicians did not know how they were performing as case managers, nor could the Authority judge how it was doing against its total capitation from the state. The Santa Barbara Authority knew its financial exposure to case managers in advance because they were capitated. But the Monterey Authority did not know what it owed until the pending claims were received for payment -- and it was too late.

C. Lessons for Other Demonstrations

Many of the lessons to be gained from the Monterey experience have been made apparent in the various sections of this report, and especially in the preceding discussion of design flaws and operational failings. This final section offers a few overall conclusions for designers of similar experiments.

It bears repeating from the first case study report that the largest lesson learned by the Initiative's staff is the need for thorough planning of all critical elements before the system becomes operational. The Monterey Initiative was under political and economic pressure to get started. There was fear that the county supervisors -- who had approved it by a vote of 3 to 2 -- would reverse themselves. Development funds were about to run out, and Initiative staff feared

loss of provider support and of momentum. Consequently, operations were allowed to begin before all the pieces were in place, and before the state and HCFA had fully acceptable protocols on the utilization control and quality assurance mechanisms.

In the political environments in which these Medicaid experiments are tried there is some value in action; several of the demonstrations were still in the planning stage when Monterey was in its second year of operation. But there are serious drawbacks to hastening the pace, and in Monterey's case they appeared in the problems with the capitation rates paid by the state to the Authority and with the information system. The original planners of the Initiative accepted rates from the state that their successors at the Authority considered inappropriate and inadequate for certain categories of enrollees whose care was unpredictable and costly. It would have taken time to negotiate further with DHS over these rates, but this was time that the planners apparently did not feel they had.

There is a need for planning and development funds as well as for time. Monterey (and Santa Barbara) got development money from the state, from HCFA, and from the John A. Hartford Foundation, but it was considered inadequate by several interviewees -- particularly with respect to developing the management information system (MIS). But the state argues that the Initiative received more than a million dollars in start-up funds, and should have been able to put an adequate MIS in place.

There is widespread agreement that a "debugged" MIS must be in place before starting operations. JBI needed at least six months and probably more to develop and test the management information system; instead, it had three. The result was a demonstration operating for many months with little idea of how well it was doing for lack of timely or reliable reports. Perhaps another contractor would have had the resources and expertise to put the system together in the available time, but JBI apparently did not.

The inadequacy of the rates for certain categories of eligibles suggests that experiments should not be too ambitious. Capitation is much easier to figure for more predictable groups like AFDC recipients, and should be limited to these groups -- at least in the beginning, until some experience is gained. The state would apparently have been willing to make such a change if the Initiative had continued.

In addition to choosing the right population, it is important to select the right site for such an experiment. Counties with already low utilization may not be the best choices for experiments that depend on achieving further substantial cuts in utilization.

An experimental program like the Initiative needs to secure support from all the important constituencies -- local political officials, providers, and community leaders concerned with the welfare of recipients. Lack of full support from the county supervisors at the outset was an unfavorable sign for a local initiative. Lacking the strong local backing that Santa Barbara had also weakened the Monterey Initiative in its dealings with the state.

Lack of enthusiasm on the part of physicians led the Initiative to offer generous financial inducements to win their participation. Yet, it seems that many case managers were unwilling or unable to practice case management as it was conceived by the Initiative's designers. This may have stemmed in part from lack of understanding about what they were supposed to be doing. There is a need to educate physicians about case management before trying to implement it, which the Initiative had the intention but neither the time nor the resources to do.

There may be an inherent conflict between the goals of increasing physician participation in Medicaid and instituting effective case management. The number of effective case managers in a given physician population may be small, so that the only way to manage care cost-effectively may be for these few physicians to enroll all the Medicaid recipients. The special task force's recommendations pointed in this direction.

Failure to generate more enthusiasm in the community for the goals of providing wider access and better care weakened the Initiative's political support. Recipients should have been its strongest advocates with local and state officials.

The Monterey Initiative also suffered from having brought its senior staff in from outside the area. They continued to be viewed as "outsiders" by many -- indeed, almost all of them remained commuters

from elsewhere -- and failed to establish meaningful bonds with the community. The choice of an outside medical director, in particular, may have reduced physicians' identification with the Initiative.

A program with such serious flaws in its design and critical problems with its operations was likely, in retrospect, to become a case study of what not to do. It is painful for those involved to demonstrate these lessons, but they may save others from the pain of having to demonstrate them again.

Evaluation of Medicaid Competition Demonstrations

Volume IV

The Florida Alternative Health Plan

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PREFACE

In September 1983, the Office of Research and Demonstrations in the Health Care Financing Administration awarded a contract to a consortium, headed by the Research Triangle Institute, to evaluate Medicaid competition demonstrations in six states: California, Florida, Minnesota, Missouri, New Jersey, and New York.

As an important part of this evaluation, case studies have been conducted at regular intervals, determined by the progress of the demonstration projects in each of the states. Team members responsible for the case studies have been from Lewin and Associates, the American Enterprise Institute, and New Directions for Policy.

The demonstration program in Florida was previously described in a case study report completed in April 1984: Evaluation of Medicaid Competition Demonstrations: The Florida Alternative Health Plan, Sean Sullivan, Joel Menges, and Maren Anderson, Prepared under Subcontract to The Research Triangle Institute, April 1984.

At the time of the earlier report, Florida officials had not yet implemented the four components of their demonstration project. Hence, the report examined the initial planning and development efforts, focusing specifically on program objectives, intended operating characteristics, and program obstacles.

This case study is based on data collected during a site visit in January, 1986. Its purpose is to trace the history of the Florida demonstration and, in an epilogue, to describe the continued development of the state's prepaid program.

Implementation difficulties caused HCFA to cease demonstration funding in Florida in August 1984 until the state could show more progress. Funding has not been renewed, although the state has continued to receive the waivers needed to implement the one remaining module still under development.

Florida has used the experience gained and the program staff built under the demonstration to continue developing its prepaid program for Medicaid recipients despite the failure of this program as a first module of the proposed demonstration. The second module, a recipient case management program, was incorporated into the regular Medicaid program in December 1984. The protocol for the third module, a prepaid plan for the frail elderly, is still being developed by the state and will be implemented later this year. The fourth module, a voucher program, was terminated in December 1984; no program was developed.

The authors are grateful to the many people in Florida who generously contributed their time and expertise during the site visit, especially Kate Guttman and her staff at the Alternative Health Plan Office of the Department of Health and Rehabilitative Services. We also appreciate the assistance received from Jack Meyer and other members of the study team.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE DEMONSTRATION

A. INTRODUCTION

The Medicaid Competition Demonstration, initiated by the Health Care Financing Administration in 1982, was designed to test the effectiveness of case management and capitation initiatives as mechanisms for controlling increases in Medicaid expenditures, improving access to care by getting more providers to serve Medicaid patients, and enhancing the quality of care provided.

The State of Florida had strong incentives to participate in this demonstration:

- Large annual increases were occurring in Medicaid expenditures, which had risen from \$43 million in fiscal year 1970-1971 to \$494.2 million in fiscal year 1980-1981.
- Physician participation in the Medicaid program had been historically low, particularly among primary care physicians. (Only 53 percent of all physicians have agreed to accept assignment; of these, only half actually deliver care to the Medicaid population.)
- The lack of primary care services had led to a strong emphasis on institutional care. In 1979-80, 65 percent of state Medicaid funds were spent on institutional care -- 32 percent for hospital care and 33 percent for nursing home care.
- Services provided to enrollees were often poorly coordinated and, in some instances, misutilized.

With funding support from the Health Care Financing Administration (HCFA), Florida initiated a demonstration project in 1982.

B. OVERVIEW OF THE FLORIDA ALTERNATIVE HEALTH PLAN

In brief, the demonstration originally involved four modules: (a) competitive alternative health plans; (b) case management for recipients who consistently overutilize medical care; (c) prepaid health plans for frail elderly patients; and (d) medical care vouchers offered by private insurers. Because Florida officials had difficulty developing and implementing the prepaid programs proposed to HCFA, demonstration funding temporarily ceased in August 1984.

1. Competitive Alternative Health Plans (Module A)

Designed as an alternative to fee-for-service reimbursement under Medicaid, this module was initially planned as a means of offering prepaid health services to Medicaid recipients through alternative plans such as health maintenance organizations (HMOs) selected by competitive bidding.

Florida originally planned to invite prepaid plans in five counties to bid for the opportunity to serve Medicaid patients. Under these contracts, the plans were to be paid 95 percent of the Medicaid historical fee-for-service cost for the counties they planned to serve.

In June 1983, Florida Medicaid issued a request for proposal (RFP) to the twelve HMOs operating in the state. Although all of the HMOs filed letters of intent to participate, only two Miami plans actually bid. Most HMOs decided not to bid because the state capitation rates were deemed inadequate. Further, the enrollment

ceiling, -- set at 10 percent of each county's Medicaid eligibles -- was considered too low, particularly since the population was to be divided among successful bidders, with the low bidder to receive the largest share and the high bidder the smallest. The HMOs also perceived the administrative requirements of the RFP to be onerous and complained that the state failed to consult with them before developing the program specifications. Eventually, the state decided to cancel the RFP and negotiate directly with HMOs.

During the state's discussions with HMOs, several Miami-based plans indicated an interest in Module A. The state, however, was unable to secure any contracts. HCFA's original interest had been to fund a competitive bidding model; when the state was unable to implement this concept, HCFA was no longer interested in supporting Module A of the demonstration. Its position was that Florida could negotiate contracts directly with HMOs under the regular Medicaid provisions of Section 1903(m) and, thus, did not need waivers to proceed.

At the time of the previous site visit (January 1984), the state was striving to initiate a prepaid program, having shifted from competitive bidding to direct negotiations with HMOs, but no prepaid contracts had yet been implemented. HMOs were not interested in prepaid contracting because of the state's low Medicaid rates, preferring the more favorable rates available through Medicare prepaid contracts.

By the time of this site visit in January 1986, the Florida Medicaid Office had, after two years of continued effort, implemented prepaid contracts with four provider organizations. As of August 1986, seven plans had prepaid contracts with the state; one of the four initial contractors was terminated while four others have been signed. These new contracts are the first ones fully developed under the new program; most of the earlier contracts had been signed with plans that had other origins and were already

operational (Palm Beach County, University Hospital of Jacksonville, and Jackson Memorial Hospital).

2. Recipient Case Management (Module B)

In Module B, Florida proposed to provide case management to 400 Medicaid recipients who are chronic misutilizers of medical services (either by overusing or underutilizing care). Initially, the state planned to test the concept using different administrative approaches in three sites. In the first site, the staff in the local Medicaid District Office were to be employed as case managers. In the second site, the state planned to contract with a local government agency. In the third, an independent contractor was to serve as the case manager.

On October 12, 1984, after the first site became operational, Florida Medicaid petitioned HCFA for approval to convert the demonstration to an ongoing state program that would employ Medicaid District Office staff as case managers. Florida's request was predicated on its statutory right to institute recipient case management, and approval was granted.

3. Alternative Health Plan for the Frail Elderly (Module C)

Florida has proposed to develop prepaid plans for the frail elderly who are eligible for nursing home care, but could continue to live independently if medical care and social services were available in their homes or in the community. A major objective of the demonstration is to control Medicaid nursing home expenditures, while improving the spectrum of services provided to elderly persons.

Under the original demonstration, prepaid plans participating in this module were required to provide basic Medicaid services as well

as home and community-based services (adult day care, case management, respite care, personal care, etc.) for a capitation rate set at 95 percent of the historical fee-for-service rate for the population eligible for nursing home admission. Enrollment would be voluntary; hence, the plans were expected to market directly to eligible patients and to offer various enrollment incentives, including such options as guaranteed extended eligibility or expanded benefits not currently offered by Medicaid.

HCFA has had continued concerns about the methodology proposed for calculating the capitation rate, which it found lacking in the several versions of the protocol submitted by the state for this module. Florida officials anticipate that a new protocol being developed will satisfy these concerns, and provide the cost information needed to develop waiver cost estimates as well. This module should begin in the latter part of 1986.

4. Selective Contracting by Private Insurers with Medicaid Providers (Module D)

This demonstration component was revised several times before the state decided to abandon the project. In its original plan, Florida proposed that Medicaid recipients would receive monthly vouchers that could be used to pay the premium for health plans offered by private insurers or prepaid health plans. Since major insurance companies were reluctant to participate in this demonstration, the state developed a new approach whereby private insurers would accept capitation payments and, in turn, contract for Medicaid services with selected providers. This module was terminated in December 1984 because Blue Cross of Florida, the only insurer to exhibit interest in the project, was unable to devote time to planning the demonstration.

C. SITE VISIT PROCEDURES

Interviews with Florida Medicaid staff and provider organizations involved in the prepaid program were conducted in January 1986. (A list of interviewees is provided in the Appendix.)

The Alternative Health Plan (AHP) Office in the Florida Medicaid Department is responsible for program activities evolving from the original HCFA demonstration project. The AHP staff is divided into two units: the Development Unit and the Management Unit. As described later in this report, particular emphasis is now being placed on the development of prepaid contracts with health plans. Activities include recruiting providers and training potential contractors to ensure that they will be able to operate high quality and financially solvent prepaid plans.

Building on the findings of the previous site visit, the site visit team set out to determine:

- The factors that have enhanced or hindered Florida's efforts to implement prepaid health plans (i.e., the lessons learned);
- The environmental changes over the last two years that have influenced the development and implementation of the various prepaid programs;
- The current goals and anticipated outcomes of the existing programs, compared to the previously planned modules;
- The provider and consumer responses to the prepayment initiative; and
- Operational characteristics of the programs and future program directions.

During the site visit, Florida officials stressed that the development of prepaid arrangements is a priority for the state's Medicaid program. The Medicaid Director has a personal goal to increase the enrollment caps for Medicaid enrollees in prepaid plans to 50,000 by the end of 1986. Moreover, in the spring of 1986 a bill was introduced in the Florida legislature that would have required all Medicaid recipients to be enrolled in prepaid plans by 1990. The bill did not pass, but the goal remains.

HCFA support has given the state momentum in this area, by educating state officials about the principles of prepayment, by stimulating interest in prepaid programs among various providers, and by providing a firm foundation for current program efforts.

In the following chapters, the specific features of the Florida approach to prepayment are described, as summarized below:

Chapter Two - Environment

This chapter presents an overview of Florida demographic characteristics, the hospital environment, features of Florida's Medicaid program, and recent Medicaid reforms.

Chapter Three - Obstacles to Implementation of Modules A, B, and D

In this chapter, the reasons for the discontinuation of Modules A, B, and D are discussed, and the evolution of Modules A and B into state-run programs is briefly described.

Chapter Four - Prepaid Plans for the Frail Elderly (Module C)

This chapter describes the planning activities that continue in support of prepaid plans for the frail elderly, focusing on key program features.

Chapter Five - Conclusions

This chapter summarizes the major findings of the site visit, addressing, in particular, the factors that will determine the success of prepaid capitation programs for Medicaid enrollees in Florida.

An Appendix lists the individuals interviewed during the site visit.

Epilogue - Prepaid Health Plans for Medicaid Enrollees

This final chapter provides an update on the state's continuing efforts to contract with prepaid plans for delivering services to Medicaid recipients, as an evolution from the competitive bidding program proposed under Module A of the demonstration.

CHAPTER TWO
THE FLORIDA HEALTH CARE ENVIRONMENT

A. INTRODUCTION

As part of a plan to improve access to care and control of its costs, Florida has embarked on a full-scale effort to establish prepaid plans throughout the state, particularly in areas with high proportions of Medicaid patients. This chapter provides an overview of Florida's health care marketplace, and suggests that increased competition has prompted many hospitals to explore ways of protecting their market shares. Recent changes in the Medicaid program are also reviewed, with special attention given to those reforms that could affect the ultimate success of the prepaid plans.

B. FLORIDA'S COMPETITIVE HEALTH CARE ENVIRONMENT

One by-product of Florida's continuing economic growth has been rapid population growth -- the state's population has grown an average of 2.9 percent per year since 1981, compared with a national average of about 1.1 percent. Because Florida is a popular retirement area, the state's elderly population has almost doubled in the past decade, and the elderly now constitute 17.3 percent of the population. The growth of Florida's major cities, particularly Miami and Fort Lauderdale, has been explosive, averaging about 3.4 percent per year between 1970 and 1983. Since 1982, Miami has also experienced an influx of more than 150,000 refugees from Haiti and Cuba.

Florida's health care market has grown dramatically to keep up with its rapidly expanding population, with the result that the state now has an excess supply of hospital beds and higher hospital

utilization than the U.S. average. The high utilization patterns may be the result of provider inefficiencies, as well as the high proportion of elderly in the population. Table II.1 shows hospital utilization for Florida and some of its metropolitan areas, compared to the average for the United States and other U.S. metropolitan areas in 1984. The data show that, when standardized for population differences, Florida has considerably more beds, inpatient days, and admissions than the U.S. average. By contrast, occupancy rates are lower in Florida and lengths of stay are shorter.

Over the past year, Florida has experienced considerable declines in patient days and occupancy rates, as shown in Table II.2.* These declines are consistent with national trends and may have resulted from the phase-in of the Medicare prospective payment system. Indeed, the state reports that Medicare patient days declined almost 10 percent during this period.

When cost comparisons are made, hospital costs in Florida are found to be higher than the averages of the United States. The American Hospital Association (AHA) reports that 1984 per diem costs were \$440 in Florida, compared with \$411 nationally. (These figures are not case-mix adjusted and in part reflect the high proportion of the elderly among Florida hospital admissions.)

Although Florida has an excess supply of hospital beds, its physician-to-population ratio is about average for the United States (165.1 per 100,000 population compared with 168.3 for the nation). Certain market areas, however, have a large surplus -- Miami has 229.8 physicians per 100,000 population, compared with

* Because of slightly different data bases, the occupancy rate reported by the Florida Hospital Cost Containment Board differs from AHA data reported in Table II.1.

TABLE 11-1

FLORIDA AND SELECTED METROPOLITAN AREAS
HOSPITALIZATION STATISTICS AREA

Hospital Statistics	U.S.	Florida	U.S. Metropolitan	Miami Ft. Lauderdale	Tampa St. Petersburg	Jacksonville
Beds Per 1,000 Population	4.3	4.6	4.4	5.3	4.6	4.6
Admissions Per 1,000 Population	149	158	154	171	170	156
Occupancy Rate	68.9	67.1	71.4	68.2	65.6	63.0
Average Length of Stay (Days)	7.3	7.0	7.4	7.8	6.4	8.0
Inpatient Days Per 1,000 Population	1,085	1,117	1,139	1,326	1,094	1,258

TABLE II.2

FLORIDA HOSPITAL UTILIZATION
1983 - 1984

	<u>1983</u>	<u>1984</u>	<u>% Change</u>
Beds Per 1,000 Population	4.9	4.8	(-2.0)
Admissions Per 1,000 Population	170	162	(-4.7)
Occupancy Rate	71.9	65.2	(-9.0)
Inpatient Days Per 1,000 Population	1,273	1,140	(-10.5)

Source: American Hospital Association

168.3 for metropolitan areas nationwide. In contrast, other large Florida cities have an undersupply of doctors, reflecting rapid population growth in recent years. For example, in 1984 the physician-to-population ratio was 133.5 in Tampa-St. Petersburg and 99.9 in Jacksonville.

Like other sunbelt states, Florida's health care marketplace has become highly competitive over the past few years. A number of alternative delivery systems, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), are now being marketed in the state.

Whereas only two years ago thirteen HMOs operated in Florida, today there are 34 plans (Table II.3). At present, about half the counties in the state are served by HMOs, with the majority of these plans serving Miami-Ft. Lauderdale (Dade and Broward Counties) and Tampa-St. Petersburg (Pasco, Pinellas, and Hillsborough Counties). Enrollment in the 34 plans exceeded 600,000 in 1985, or 5.5 percent of the population, and in the next few years the number of HMOs in Florida is projected to increase rapidly. Although the state insurance department would not reveal the number of pending HMO licensure applications, a source indicated it could exceed 100.

To encourage PPO development, Florida enacted legislation in 1983 allowing insurance carriers to enter into selective contracting arrangements. At least 25 PPOs are operational in Florida, including plans operated by Metropolitan, Aetna, Travellers, and Equitable. Several investor-owned hospital groups, such as National Medical Enterprise, Humana, and American Medical International, have also begun to market PPO plans in Florida.

As private purchasers have promoted hospital price competition, hospital institutions have had less flexibility to provide uncompensated care to indigent populations. Proprietary and nonprofit hospitals, in particular, are shifting charity care to

TABLE II.3

FLORIDA HMOs -- 1985

<u>Total</u>	34
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Model

IPA	16
Staff	12
Combination	5
Not Available	1

Profit Status

Profit	31
Non-Profit	3

Federally Qualified

Yes	16
No	18

Years Operational

0 - 1	13
2 - 5	11
6 +	10

Service Areas (By County)*

Alachua	1	Lee	1
Baker	4	Leon	2
Breward	3	Manatee	2
Broward	10	Nassau	4
Clay	5	Orange	7
Dade	15	Osceola	4
Duval	5	Palm Beach	9
Escambia	2	Pasco	9
Flagler	2	Pinellas	9
Gadsden	2	Polk	3
Hendry	1	Putnam	1
Highland	1	Santa Rosa	2
Hillsborough	9	Sarasota	1
Jefferson	1	Seminole	7
Indian River	1	St. Johns	5
Lake	4	Volusia	5

*Most plans serve more than one county.

Source: Florida Department of Insurance

public hospitals, which often have difficulty absorbing the additional financial burden. In 1983, Governor Robert Graham convened a task force to examine health care cost containment and indigent care, and in the summer of 1984, the Florida Legislature enacted legislation in response to some of the task force recommendations. The legislation expanded Medicaid eligibility and assessed hospitals one-and-a-half percent of their net patient revenues to pay for part of the expansion. A portion of this funding has been allocated for the delivery of primary care by county health units. The state is currently considering additional financing and program proposals to solve the indigent care problem.

Health care cost containment has become a major concern of employers and other purchasers in Florida, who have become involved primarily through local business coalitions. In addition to community activities, the coalitions have been working at the state level to ensure that hospital data will continue to be available for employers to use when selecting alternative delivery systems.

As shown in subsequent sections of this report, competition for Medicaid patients is also beginning to be observed. Although the current Medicaid reimbursement rates are too low to encourage many new providers to enter this market, existing providers are acting to preserve their market share and, possibly, to expand it.

C. CHANGES IN FLORIDA MEDICAID

Florida Medicaid has carefully controlled increases in program expenditures in the past several years. The state has not raised its physician reimbursement rates since 1972 and, as a result, fewer than 15 to 20 percent of licensed physicians participate in the program on a regular basis. In 1983, the state implemented prospective payment

for nursing home services, in an effort to control Medicaid outlays. Other cost control measures include a limit on covered hospitalization (45 days per year) and a cap on reimbursement for outpatient visits (\$100 per person per year.) On July 1, 1984, the reimbursement cap for outpatient visits was raised to \$500 per person per year.

The state has continued to add cost-saving adjustments to its program, for example, requiring that certain surgeries be performed on an outpatient basis. These and other similar changes enabled Florida to reduce the rate of increase in Medicaid acute care expenditures from 21 percent in FY 1982 to 12 percent in FY 1983 and 11 percent in FY 1984. (Table II.4). In addition, the state experienced a significant decline (36 percent) in hospital outpatient expenses. By contrast, nursing home expenditures have grown rapidly in recent years (13 percent in FY 1983 and 28 percent in FY 1984), with expenditures for the elderly SSI recipients, the smallest Medicaid group, representing 80 percent of total program expenses (Table II.5).

In FY 1985, Florida added a number of benefits to the Medicaid program, including community mental health clinic services, podiatry, birthing centers, and ambulatory surgery centers. In addition to these services, Florida Medicaid offers several other optional services, including a program that assesses the needs of individuals who are candidates for nursing homes and arranges community services for them. Another program provides "home and community-based services" to elderly persons who are eligible for nursing home care.

Florida has also expanded the number of groups that are eligible for Medicaid. Traditionally, the following groups have been covered:

- Categorically related persons who are receiving cash payments from the Aid to Families With Dependent Children (AFDC) program (i.e., families deprived of parental support due to desertion or disability) and the Supplemental Security Income (SSI) program (i.e., aged, blind, and disabled adults);

Table 11.4

SUMMARY OF FLORIDA MEDICAID EXPENDITURES

<u>SERVICES</u>	<u>FY 1981</u>	<u>FY 1982</u>	<u>% CHANGE</u>	<u>FY 1983</u>	<u>% CHANGE</u>	<u>FY 1984</u>	<u>% CHANGE</u>
Hospital							
Inpatient	\$146,318,937	\$177,580,686	21.4%	\$198,741,605	11.9%	\$219,660,028	10.5%
Outpatient	26,717,157	27,684,775	3.6%	28,283,578	2.2%	17,992,893	(36.4%)
Nursing Home	156,651,906	176,912,290	12.9%	200,938,757	13.6%	256,112,509	27.5%
Physician	40,925,076	43,493,659	6.3%	42,827,079	(1.5%)	42,238,840	(1.4%)
Other	123,563,827	155,281,489	25.7%	219,435,844	41.3%	259,218,398	18.1%
Total	\$494,176,903	\$580,952,899	17.6%	\$690,226,863	18.8%	\$795,222,668	15.2%

Source: Florida Department of Health and Rehabilitative Services.

Table II.5

FLORIDA MEDICAID PAYMENT ELIGIBILITY CATEGORY

FY 1984

<u>Category of Assistance</u>	<u>Eligibles</u>		<u>Payments</u>	
	<u>Number</u>	<u>Percent</u>	<u>\$</u>	<u>Percent</u>
SSI	191,654	38.9%	\$634,600,697	79.8%
AFDC	301,575	61.1%	\$160,621,971	20.2%
TOTAL	493,229	100.0%	\$795,222,668	100.0%

Source: Florida Department of Health and Rehabilitative Services.

- Individuals under the age of 18 who are in foster care;
- Individuals living in institutions; and
- Individuals receiving General Assistance (GA), including refugees who are not eligible for AFDC or SSI.

Effective July 1985, the state expanded eligibility to cover several previously uncovered groups whose inclusion in Medicaid is optional: financially eligible children in intact families, financially eligible families with an unemployed parent, and financially eligible pregnant women in intact families. Beginning in July 1986, a Medically Needy program will be added for persons with incomes up to 133-1/3 percent of the AFDC payment standard, after medical expenses. The medically needy will be eligible for all of the benefits offered through Florida Medicaid, except long-term care.

The Medicaid program has set several program goals for the next few years. The first is to establish community-based long-term-care services as an alternative to nursing homes. To achieve this goal, the state is studying the feasibility of establishing social/HMOs -- prepaid plans for Medicare patients that cover a comprehensive range of services including long-term care.

The second goal is to establish prepaid plans throughout the state. The Chairman of the Health Care and Insurance Committee of the Florida Assembly introduced a bill that would have required Medicaid to enroll all of its recipients in prepaid plans by 1990. While the bill was ambitious and did not pass, its intent is consistent with the Department of Health and Rehabilitative Service's (DHRS) objectives.

Florida's involvement in prepaid plan contracting for Medicaid recipients is long-standing, predating the HCFA demonstration. Starting in 1981, DHRS began contracting with the Palm Beach County

Health Unit. At about the same time, the University Hospital of Jacksonville was awarded a HCFA demonstration grant for financially distressed hospitals that funded the operation of a prepaid plan offering primary care case management to 3,800 Medicaid eligibles and 5,300 Medically Needy recipients. (Both of these prepaid plans - Palm Beach County Health Unit and University Hospital of Jacksonville - are contractors under the state's current prepaid program.) To expand these efforts, Florida received HCFA demonstration support in 1982 under the Medicaid Competition Demonstration to implement four demonstration projects to test capitation and case management programs.

Although for reasons described previously the Medicaid Competition demonstration has ended (with the exception of prepaid plans for the frail elderly), the state has, nonetheless, implemented several prepaid contracts under authority granted by Section 1903(m) of Title XIX, the federal Medicaid statute. Recently, in order to increase the state's contracting flexibility, the Florida legislature adopted a new law permitting the Medicaid office to implement contracts with prepaid plans that are not state-licensed. These modifications have made it possible for traditional Medicaid providers, such as hospitals and physician groups, to form prepaid plans for purposes of contracting with the state.

Although Medicaid prepaid plans are exempt from state insurance codes, they must meet the requirements of the federal Medicaid program. Compliance with these regulations may prove to be difficult for some of the Florida plans. For example, HCFA requires that Medicare and Medicaid beneficiaries represent less than 75 percent of total plan enrollment. This requirement can be waived for up to three years for new HMOs, but the HMO must make continuous efforts to achieve compliance. Several of Florida's proposed plans are county hospitals and public health clinics, and may have difficulty

recruiting private-paying enrollees. Some plans, however, may attempt to enroll indigent patients (who typically receive state general assistance) as a means of achieving compliance.

In summary, Florida has a continuing commitment to prepaid plans for Medicaid recipients, and has encouraged various types of potential contractors to develop them. The state's progress in implementing these contracts is described in the epilogue to this report.

CHAPTER THREE
OBSTACLES TO IMPLEMENTATION OF MODULES A, B, AND D

A. INTRODUCTION

Both Module A and Module D of the Florida Alternative Health Plan demonstration encountered opposition from key interest groups and were never implemented. Module B, Recipient Case Management, was partially implemented, but was quickly converted from a demonstration to an ongoing state program.

This chapter describes each of the three modules and discusses the barriers that Florida Medicaid encountered. Finally, the current status of each program is reported and conclusions of interest to other states are presented.

B. COMPETITIVE ALTERNATIVE HEALTH PLANS (MODULE A)

1. Origin and Overview of the Demonstration

The overall purpose of Module A was to determine the feasibility of contracting for delivery of Medicaid services on a prepaid basis, using a competitive bidding process to obtain the lowest rates possible while maintaining an acceptable level of quality. Florida sought to make prepaid care available to the Medicaid population in a fair market setting -- one offering recipients a choice among plans, which in turn would compete for larger shares of the Medicaid "market." The state's ultimate objective was to increase Medicaid recipients' enrollment in alternative health plans in several counties above the national average of two percent.

Florida was already conducting a prepaid demonstration in one county, where the state was contracting with the county health department to serve AFDC recipients. It could have tried to develop more such programs with other local health departments, but chose instead to contract with existing HMOs in several counties to broaden provider involvement in the program and encourage competition.

The Florida statute under which the RFP was issued would have allowed the state to negotiate directly with HMOs without soliciting competitive bids, but a bidding process was perceived as potentially generating more competition. Only when the response to the RFP proved disappointing -- two bids were received, both from Dade County (Miami) -- did the state turn to direct negotiations, abandoning the competitive bidding process that had constituted Module A of the demonstration.

2. Obstacles to Implementation

The RFP sent by the state to federally and state-qualified HMOs produced 12 letters of intent, but only two bids. There were several explanations for the lack of response by HMOs. The low capitation rates -- from \$42.95/month in Dade County to \$55.80/month in Pinellas County (Clearwater) -- were derived from Florida's low Medicaid payment level (45th in the U.S.) and offered little financial incentive to participate. In addition, HMOs were concerned about their ability to negotiate financially acceptable rates with hospitals, which, they argued, were unwilling to bargain to serve Medicaid patients because of the large number of Medicare patients available. To circumvent this problem, the HMOs wanted the state to remove hospital inpatient costs from the capitation altogether and continue to pay hospitals directly.

Another deterrent to HMO participation was the arbitrary cap placed by the state on the number of Medicaid eligibles that could be

enrolled in each county. This cap was set at 10 percent of the county's total Medicaid-eligible population and was to be divided among successful bidders with the low bidder getting the largest share. The state has since eliminated this ceiling, in keeping with its decision to enroll more Medicaid recipients in prepaid plans.

The enthusiasm of the HMOs for the demonstration was also dimmed by what they perceived as an onerous amount of detail in the RFP. The state, of course, argued that the requirements in the RFP were not as burdensome as they appeared, but the point became moot when the competitive bidding process was abandoned.

The high degree of turnover within the Medicaid-eligible population, with individuals continually going on and off the rolls, was another discouragement to HMOs considering participation in the demonstration. Keeping up with a constantly changing group of enrollees is an administrative burden, and HMOs wanted the state to offer a period of guaranteed eligibility as some other states had done in their prepaid demonstrations. This would also have acted as an incentive for Medicaid recipients to enroll, helping the HMOs to market a voluntary program that offered no additional benefits beyond those of the existing Medicaid program.

The unwillingness of the state to offer extended benefits or guaranteed eligibility, while acting as an obstacle to HMO participation, also exemplified what the plans felt was a larger failure on the state's part -- its unwillingness to involve them in helping to design a workable demonstration. They felt left out of the planning process for the RFP, and believed that the state took their participation for granted. One HMO characterized the situation as one of state officials "sitting up there (in Tallahassee) while we are sitting down here, when we should be sitting down together."

3. Current Status

Florida's Alternative Health Plan Office has responded to this last criticism through the changes instituted in the program developed after Module A's failure. In its current negotiations with prepaid health plans, the state has replaced the arms-length process tried under Module A with a much "friendlier" approach.

The state now recognizes that it must be willing to help plans to develop, if it is to realize its own objective of moving toward a prepaid Medicaid system. This approach entails marketing the prepaid program to providers (including those already serving Medicaid patients), assisting with feasibility studies, providing information on the distribution of Medicaid recipients by hospital market area, and reviewing proposed plan organization prior to contract approval. This new program is described more fully in the epilogue.

C. RECIPIENT CASE MANAGEMENT (MODULE B)

1. Origin and Overview of the Demonstration

Module B, Recipient Case Management, was the only module of the Florida Alternative Health Plan to be partially implemented. By December 1984, the Florida Medicaid Program Integrity Unit was successfully operating a single case management site in Hillsborough County (the Tampa-St. Petersburg area). Soon thereafter, they converted the project to an ongoing state program.

The Medicaid Program Integrity Unit designed the Recipient Case Management Module of the Florida Alternative Health Plan. The Unit had previously operated an ad hoc management system for Medicaid recipients. When the HCFA competition demonstration was announced,

the Unit saw an opportunity to design and test a more formally organized recipient case management approach. In particular, the state proposed to test several organizational configurations for administering the program.

Initially, Module B was targeted to 17,000 Medicaid recipients (roughly 3 percent of all enrollees) who were possible misutilizers of services. The demonstration was designed to reduce inappropriate overutilization of medical services and to assure that medically high-risk patients were not underutilizing services. Initially, recipients were given an opportunity to correct misutilization voluntarily. However, if they did not change their behavior, they were subject to four levels of progressively more restrictive controls:

- Level One: The case manager interviewed the recipient to determine whether there was a medical justification for the observed use patterns, or whether he or she needed case management. High users with medical justification were classified as "high risk" and monitored. Recipients with unjustified high use patterns were given informal counseling on how to use the health care system.
- Level Two: The case manager worked intensively with the recipient to provide counseling and education on the proper use of the Medicaid program. Case managers also contacted providers and requested their assistance in controlling the problem. The recipient's Medicaid card was encoded to indicate participation in case management.

- Level Three: Recipients and their providers were required to obtain prior authorization for all non-emergency care. The Medicaid card was coded with instructions on how to obtain prior authorization. Case managers continued to provide counseling to recipients who were encouraged to correct their utilization behavior.
- Level Four: The case manager selected a primary care provider and pharmacy from whom the recipient obtained all non-emergency care. The recipient's Medicaid card was imprinted with instructions about Level Four procedures and the name and address of the lock-in providers whom they were required to use.

The state planned to test different ways of administering the program in three sites: Hillsborough, Orange, and Duval counties. In Hillsborough County (Tampa - St. Petersburg), employees of the Medicaid District Office served as case managers. In Duval County, a local government agency, such as the county health or social services department, was to be assigned case management responsibilities. In Orange County, an independent agency was to be contracted with to serve as the case manager. The rest of the state was to serve as a comparison group for the demonstration. In non-project counties, the state would refer misutilizers to the Medicaid District Offices, which would provide ad hoc assistance.

2. Obstacles to Implementation

The Medicaid Program Integrity Unit encountered a number of problems that delayed initial implementation of Module B at the Hillsborough County site. In response to these difficulties,

Florida notified HCFA on October 12, 1984, that it was terminating Module B and noted that Federal waivers might not have been necessary to implement the program. The project was then converted to an ongoing state-controlled program.

Although planning for Module B began in 1982, the first site did not become operational until the spring of 1984. Among the problems that contributed to the long planning phase and the delays in the scheduled implementation was a complaint made by Jacksonville Area Legal Aid, Inc. The Legal Aid attorneys submitted two petitions requesting invalidation of the state's regulations governing recipient case management. The first, filed in October 1983, contested the original proposed rule and the second, filed in February 1984, asked that the revised rule be overturned. An administrative hearing officer upheld the rule and the state was able to proceed with implementation, though somewhat behind schedule.

Delays were also encountered when EDS, the Medicaid fiscal intermediary, took longer than expected to program its system to administer the demonstration. Finally, the start-up in the initial site, Hillsborough County, was time-consuming because it entailed hiring case managers and developing procedures.

In addition, the state encountered some difficulties when plans were being developed for contracts with a local government agency in Duval County and an independent agency in Orange County. Since the Medicaid District Office staff were performing well in Hillsborough County, the state decided to abandon the idea of testing several administrative models. Instead, they chose to implement the Medicaid District Office model statewide.

3. Current Status

Module B of the Florida Alternative Health Plan was unusual, primarily because it did not actually experiment with competitive strategies, but rather sought to discipline patients with aberrant use patterns. Since a number of states have already instituted case management programs under existing Medicaid program authority, HCFA has questioned whether Florida needed demonstration waivers to test its approach. Thus, when Florida discovered that its plan to test various administrative models was not practical, it converted the project to a state-operated program.

The Recipient Case Management program is now operating on a statewide basis with District Office staff in each county serving as case managers.

D. SELECTIVE CONTRACTING BY PRIVATE INSURERS WITH MEDICAID PROVIDERS (MODULE D)

1. Origin and Overview of the Demonstration

The original Module D of the Florida Alternative Health Plan demonstration was called a "medical care voucher program." Under the program, Florida Medicaid planned to offer recipients monthly vouchers that could be used to pay the premium for a health plan of their choice offered by private insurance companies or prepaid health plans. The objective was to permit Medicaid recipients to make fair market choices among health care plans and to foster competition among plans.

The state planned to issue vouchers to 1,000 recipients in Dade, Hillsborough, and Alachua counties. The vouchers would have been set

at 95 percent of the Florida fee-for-service equivalent for the enrolled population and could only have been redeemed for the purchase of state-approved health plans offering a minimum array of services comparable to Florida Medicaid benefits. (Nursing home care was excluded.)

While participation in the voucher program would have been voluntary, the state devised several incentives designed to attract enrollees. Recipients would have received guaranteed six months extended eligibility and the opportunity to purchase health plans with broader benefits, if they were willing to pay out-of-pocket for additional premiums. The state also planned to award cash rebates to recipients who purchased health plans with lower premiums than the voucher amount.

Unfortunately, Florida's major insurance companies were not interested in participating in the voucher program. The voucher value was too low for the companies to be able to provide acceptable benefits. In addition, the companies were not interested in competing for such a small population of only 1,000 recipients.

In the fall of 1983, the Alternative Health Plan staff revised its approach to Module D in an attempt to rekindle the insurers' interest. In lieu of the voucher approach, the state proposed a selective contracting system that would entail paying participating insurers a capitation amount for Medicaid enrollees who would then have access to a limited panel of selected contract providers.

The state found that only Blue Cross and Blue Shield of Florida was willing to continue discussions on the revised Module D. Blue Cross officials stressed, however, that they could not develop a proposal until their new Medicare HMO was fully operational. To date, discussions have not been reopened and the state has temporarily decided to cease planning activities.

2. Barriers to Implementation

During the initial stages of the project, the inexperience of state negotiators in dealing with private insurers caused some problems. However, the chief barriers to successful implementation of Module D were the low voucher fee and capitation rate that Medicaid offered to pay. At these payment levels, the insurers were not confident of the financial success of the voucher program since they did not believe that they could obtain any better rates with providers than Medicaid had already negotiated through the fee-for-service system. Finally, other deterrents to the program were the existing ventures in which insurers were already involved, including Medicare HMOs, which promised greater returns on investment.

3. Current Status

For two years, Florida Medicaid attempted to develop a viable approach to Module D, but ceased its efforts when it became apparent that private insurers were not interested.

Since December 31, 1984, Module D has been eliminated from Florida's Alternative Health Plan demonstration.

CHAPTER FOUR
MODULE C - PREPAID PLANS FOR THE FRAIL ELDERLY

A. INTRODUCTION

Florida has given top priority to the development of community care programs for the frail elderly, including a commitment to prepaid health care for those eligible for institutionalization who could reside in the community.

One problem delaying the implementation of this program has been the difficulty in achieving agreement with HCFA over the calculation of the capitation rate. HCFA officials asked for more justification for the rate-setting process, and expressed particular concern about the small size of the claims being used for calculating rates. State officials have developed revised cost estimates based on a larger population to justify the more recently proposed capitation rates.

Only one provider has been chosen to test this pilot program, and state officials believe that the strength of this module is the integrity and reliability of Mt. Sinai Medical Center of Greater Miami. The state is developing a project to last three years, during which time the contractor will be given considerable freedom in operating it. The only concern that state officials expressed was that the plan may not prove financially viable.

The objective of the pilot program is to determine whether patients can be diverted from nursing homes and, through this process, service delivery costs can be reduced. A capitated rate will be established on the basis of historical claims experience from Dade County.

B. PROVIDER PROFILE

Mt. Sinai Medical Center has a long-standing commitment to the provision of comprehensive services to the elderly in its market area, and has been accomplishing this objective over the past 10 years through its own program, Project Sinai. This program has a provider team of health professionals, social workers, and case managers. Services provided include: inpatient and outpatient care, transportation, home assessment, pharmacy counseling, dietician services, emergency response, rehabilitation, escort services, family services, home health, and homemaker services.

About 450 persons are currently served by Project Sinai, with fee-for-service payments received from Medicare and Medicaid and from other service agencies. Mt. Sinai officials intend to use the Project Sinai program as the basis for the prepaid service plan that is now being developed.

The major obstacles to the implementation of this prepaid plan, from the perspective of hospital officials, are:

- Eligibility Levels -- Florida officials currently require that individuals have income of less than \$800 a month to be eligible for Medicaid payment for institutional services. Mt. Sinai officials are concerned that this eligibility level may reduce the number of persons eligible for the prepaid program

below the level at which it can be financially viable (estimated at 400 enrollees).

- Payment Rates -- Mt. Sinai staff believe that the rate currently being discussed is low because it does not include enough for the cost of providing community services. Moreover, the claims experience is not complete because many physicians do not submit claims, believing the Medicaid rates to be so low as not worth the trouble. Medicaid payment limits also distort the historical claims. The Florida Medicaid program has not paid for hospital days over 45 days per year (irrespective of the number of stays) nor for outpatient services over \$500; hence, expenses associated with this service use are not included in the claims data base.

Mt. Sinai staff see the prepaid plan for the elderly as a "risky" program. They believe that the elderly can be kept out of nursing homes, but that the costs of doing so "are the same, if not more" than the cost of institutional care.

C. PROGRAM STATUS

Recently, the state of Florida resubmitted the research protocol to address the concerns expressed by HCFA demonstration staff. The protocol was submitted to HCFA on April 2, 1986, and if it is approved, the project will begin later this year.

The new protocol outlines a revised ratesetting methodology that the state describes as "comprehensive." The rate encompasses costs

for all medical services incurred by eligible patients (including hospital and nursing home care) as well as home and community-based services.

At the time of this writing, the AHP staff was finalizing the rates in the operating protocol before submitting it for HCFA's approval and remained eager to initiate the demonstration project.

CHAPTER FIVE

CONCLUSIONS

The Florida Department of Health and Rehabilitative Services (DHRS) benefited considerably from the Medicaid Competition Demonstration funding from HCFA, despite the fact that during the demonstration only one of the four modules -- the recipient case management program (Module B) -- became operational. HCFA funding enabled DHRS Staff to develop expertise in prepayment mechanisms, to publicize the prepayment concept throughout the state, and to lay the groundwork for the program that is now operational. Florida Medicaid has prepaid contracts with seven plans under contracting authority granted by Section 1903(m) of Title XIX of the Social Security Act. The principles underpinning the state's current contracting activities were derived from the "trial and error" of the competition demonstration. This chapter reviews the lessons learned from Florida's demonstration project, which the state is applying to its current prepaid program. Many of the issues discussed may be relevant to other states considering similar programs.

1. Lessons Learned from the Initial HMO Demonstration

Florida's Medicaid reimbursement rates for hospital and physician services are considerably lower than commercial rates. Since the state has not increased physician rates since 1972, only a small proportion of Florida physicians (15-20 percent) participate in Medicaid with any frequency. Thus, one of the primary reasons that

the Florida Medicaid office initiated HMO contracting was to create better access to care and to improve continuity of services for Medicaid recipients.

When the state announced its prepaid program and invited HMOs to bid, however, the response was very poor. The HMOs were reluctant to participate in a program offering such a low capitated rate (set at 95 percent of historical expenditures), particularly when other more attractive opportunities, such as Medicare HMOs, were available. Moreover, the state asked bidders to submit proposals covering administrative and procedural details far more onerous than ordinarily required in the private marketplace. Discussions were also conducted at "arms-length," through a formal bidding process that created an adversarial atmosphere. In the end, the competitive bidding process broke down completely, and the state was forced to reconsider its approach.

The failure of the bidding process under Module A of the demonstration taught the state several lessons:

- First, the state cannot dictate terms in a "soft" market. Florida's low Medicaid rates are not particularly attractive to commercial HMOs and, therefore, the state has had to cultivate provider interest, rather than dictate terms. The arms-length bidding process has been replaced by open negotiations with interested providers, allowing for some flexibility in the program design.
- Second, contract terms must be flexible enough to accommodate HMOs' special concerns. State officials realized this when they removed the 10 percent caps on target enrollment in the plans' service areas.
- Third, Florida did not fully appreciate the barriers to contracting with commercial HMOs. For example, many HMOs have

existing hospital contracts that require them to pay daily rates higher than Medicaid rates. These contracts cannot be set aside for the Medicaid program. Recently, the state has solved this problem by offering to continue paying hospitals regular Medicaid rates, and reducing the monthly payment by the amount of inpatient expenditures incurred during the previous month. Under these arrangements, the HMO continues to be at-risk for the cost of hospitalized patients.

- Fourth, Florida Medicaid has come to realize that, given these barriers, commercial HMOs may not be the best potential contractors, and has expanded the scope of its program to include hospital-based, physician-sponsored, and other provider-organized prepaid health plans.

While these changes may overcome some of the biggest problems encountered in the demonstration, one problem remains -- Florida's low Medicaid payment rates, on which the prepaid plan rates are based.

2. The Evolution of State Support for Prepaid Health Plans

In 1982, when Florida's Alternative Health Plan demonstration began, the state had little prior experience with prepayment (with the exception of the Palm Beach County experiment). In large measure, HCFA's demonstration funds enabled the state to gain expertise in this area, and to generate political support for the program.

The HCFA demonstration funding allowed Florida Medicaid to staff an Alternative Health Plan Office with individuals who developed expertise in prepayment. The staff learned rate-setting methodologies, developed contract negotiation skills, and established administrative procedures for monitoring the performance of prepaid plans.

3. A Marketing Approach to Prepaid Plan Contracting

Competitive pressures in the Florida health care market have enhanced the attractiveness of Medicaid patients and, concomitantly, the appeal of the Medicaid prepayment programs, yet, state officials still see the Alternative Health Plan as a program that "has to be sold." In contrast with the earlier competitive bidding process, under which a request for proposal was sent to prospective contractors, AHP staff actively solicits provider participation by marketing the prepaid plan concept.

4. Incentives for Providers to Develop Medicaid Prepaid Plans

Prepaid programs that put providers "at-risk" require careful development efforts. In the past, the incentives associated with the creation of such programs were outweighed by the limited reimbursement available through the Florida Medicaid program and the burdensome administrative requirements.

The Florida Alternative Health Plan Office now conducts open negotiations with prospective contractors, and the providers who have responded (primarily hospitals) have clear incentives to participate in the program. With declining admission rates, the Medicaid market is becoming more attractive to hospitals competing for market share, even with low reimbursement rates.

5. Selection of Prepaid Health Plans

The original Module A demonstration limited provider participation to HMOs. Although the state is anxious to negotiate

contracts with HMOs, the providers who have implemented plans so far have been those not traditionally involved in operating prepaid plans: hospitals, a health department, and a physician's group. In contracting with prepaid plans, the state's original intent was to encourage greater physician participation in Medicaid, yet the contracts negotiated to date have tended to be with closed-system institutional providers. One of the hospitals implementing a program this spring is planning to establish an IPA-type network of primary care physicians, but this is an exception thus far.

6. Scope of Services Included in the Prepaid Program

Under the HCFA-funded demonstration, Florida's AHP office had proposed to put providers at-risk for all Medicaid-covered services. The current state program has maintained this objective, and all the plans are at risk for a broad range of inpatient and outpatient services. Continuing to negotiate prepaid plans for a comprehensive range of services, however, may be difficult in the future.

Developing prepaid plans for long-term care services continues to be a state priority, yet, finding providers willing to be at-risk for these services has been difficult. Mt. Sinai Medical Center, the one provider willing to serve as a pilot site for Module C, the prepaid program for the frail elderly, has been hesitant to finalize an agreement with the state until the reimbursement rate is worked out and eligibility standards are specified. The protocol for this remaining segment of the demonstration has been revised several times, and must be approved by HCFA before the program can become operational.

APPENDIX

Persons Interviewed During The Site Visit To Florida

January 1986

Kate Guttman
Director, Alternative Health Plan Office
Department of Health and Rehabilitative Services

Judy Mitchell
Director of Medicaid
Department of Health and Rehabilitative Services

Karen Stanford
Manager of the Development Unit
Alternative Health Plan Office

Thomas Stockdale
Manager of the Management Unit
Medical/Health Care Program Manager
Alternative Health Plan Office

John Udell
Administrator, JMH Plan
Jackson Memorial Hospital

Chris Adams
HMO Manager
AMI Group Health Services, Inc.

Jeffrey Prussin
Senior Vice President
Government Programs and Plan Development
International Medical Centers

David Spivack
Director of Planning
Mt. Sinai Medical Center

Luis Lamela
Vice President for Operations
CAC, Inc.

Emmett Johnson
Administrator
University Hospital Health Plan, Jacksonville

APPENDIX
Continued
Persons Interviewed During
The Site Visit To Florida

January 1986

Michael Hansen
Staff of Florida Senate Health and Rehabilitative Services Committee

Lynn Clapper and Lawrence Polivka
Staff in the Governor's Office

Ronald Deacon
Project Officer
Office of Research and Demonstrations
Health Care Financing Administration

EPILOGUE

PREPAID HEALTH PLANS FOR MEDICAID ENROLLEES

A. INTRODUCTION - PROGRAM OBJECTIVES AND OBSTACLES

Compared with the planning activities of two years ago, Florida now has prepaid contracts with several plans and is actively seeking additional plan sponsors. State officials report "a lot more interest" on the part of providers, prompted in part by increasing competition within the health care marketplace. As one state official put it, "With the commercial market getting carved up, Medicaid is looking more attractive." This is occurring even though Florida Medicaid reimbursement rates continue to be low; Medicaid pays only \$10 for a physician office visit and the prepaid plan rates are set at 95 percent of the average fee-for-service claims. Nonetheless, increasing numbers of providers appear willing to work within these limits in setting-up prepaid plans, particularly those providers who already serve substantial numbers of Medicaid patients.

Protecting market share, improving cash flow through prepayment, improving the services provided, and even making a slight profit -- these are the incentives to plans that have negotiated or are negotiating prepaid contracts with the state Medicaid office. Development of a prepaid plan for Medicaid enrollees is often a defensive move, either to ensure continued market share or to permit diversification of a hospital's patient base. State officials, enthusiastic about current provider response, believe more providers will choose to participate when they realize the potential for profit.

From the state's perspective, a competitive environment is seen as a way of stimulating better service delivery for Medicaid recipients by improving the access to and quality of care delivered. Potential cost savings are also appealing to state officials, particularly given the state's ability to control increases in capitation rates from year to year.

In contrast to two years ago when HMOs were the only prepaid plans invited to implement Medicaid prepaid plans, Florida officials have now broadened the categories of plan sponsors being considered to include hospital-based HMOs, physician groups, public health departments, and primary care centers. State officials characterize their initial approach (competitive bidding through a request for proposals cycle) as an "arms-length" process in which no providers were willing to participate. They believe that they have now evolved a relatively "friendlier" approach to plan development because, as one official put it, "This is a program that has to be sold."

By working closely with providers before contracts are signed, state officials make sure that providers are aware of their risk obligations and that they are capable of providing high quality care, while remaining solvent.

Although the original program elements have been "streamlined," the contract requirements developed for Module A (competitive bidding for HMOs) are the basis for the prepaid contracts currently being negotiated. As originally planned, Florida officials negotiate a comprehensive prepaid service package to be delivered for an all-inclusive capitated rate. (Long-term care is not included.) Plans are totally "at risk," and must set up their own risk reserves. (More information on the rate-setting procedures is provided in a later section.)

Despite the wide range of sponsors interested in the prepaid contracts, state officials note that a lot of technical assistance will be required before many of the proposed plans become "well-versed in HMO philosophy." When asked about the continuing obstacles to promoting prepaid plans for Medicaid recipients, state officials described four problem areas:

- 1 Marketing - Marketing to Medicaid recipients is difficult, because of the plans' inexperience and the difficulties of marketing to a population that is constantly moving in and out of the Medicaid program. Plans have also had to develop marketing strategies that limit the potential for adverse selection, by expanding recruitment efforts beyond current patients who are already ill and need medical care. Moreover, it is difficult to get Medicaid recipients to give up their freedom of choice when they enroll, even when additional benefits are offered.
- 2 Turnover - Florida's Medicaid program extends eligibility only for a 30 day period; each month it must be renewed. Hence, the turnover rate (including both loss of eligibility from income gains and unintentional terminations because the recipient forgot to renew) is high, disrupting enrollment in the prepaid plans. Although some proposals have recommended that eligibility be offered for six months, Florida officials report that this change is not likely to be made in the near future.
- 3 Limited HMO Expertise - Many providers need substantial assistance, having no experience managing risk or other aspects of prepaid plans.

- 4 Low Capitation Rates - Despite the current interest in prepaid contracts, low payment rates are a deterrent to participation. Capitated rates are set at 95 percent of the Medicaid fee-for-service payments. Since the fee-for-service rates are low, prospective plans believe that the capitated rates do not offer a sufficient margin to cover all of the Medicaid benefits.

B. PLANNING ACTIVITIES

Staff members from the Alternative Health Plan (AHP) Office are currently putting a great deal of emphasis on development efforts, ranging from program marketing to the technical assistance required to help applicants develop suitable plans.

Exhibit 1 shows the scope of these pre-contract activities. According to state representatives, a year is generally required "to bring a plan up." Of the seven prepaid plans that currently have contracts with the state, three had been operational before contracting with the state; the other four have been "developed" as part of the new prepaid contracting program. Plans currently operating are: Palm Beach County Prepaid Health Plan, University Hospital of Jacksonville, Jackson Memorial Hospital, Mt. Sinai Medical Prepaid Plan, Southeastern Family Health Plan, and INED Clinic/HMO.

Florida officials are consciously looking for different types of plan sponsors, although they recognize that some organizations will be more capable than others of operating a prepaid plan. State officials stress the importance of financial solvency and underscore the risk these plans will assume, in order to ensure that those sponsors who are not familiar with prepaid plans will understand their obligations.

EXHIBIT 1
PLAN DEVELOPMENT PROCESS
FLORIDA ALTERNATIVE HEALTH PLAN OFFICE
SEQUENCE OF EVENTS

INITIAL MEETING

During this session, state officials discuss the advantages of a prepaid plan with the provider, describing if necessary how health maintenance organizations work, and discussing the provider's existing and potential Medicaid market.

SECOND MEETING

The state prepaid plan contract is reviewed step-by-step with a prospective contractor. Those candidates who are seriously interested in establishing a prepaid plan are encouraged to sign a letter of intent.

ADDITIONAL MEETINGS AND PHONE CONFERENCES

Continuing contact is maintained with prospective contractors on an "as needed" basis.

FEASIBILITY STUDY

A comprehensive review is recommended as a means of assessing the market potential and financial feasibility of a Medicaid prepaid plan. Historical utilization data by geographic area and by eligibility category are provided. Financial solvency is a particular state concern. Prospective plans are asked to develop estimates of their development costs and to project costs/revenues for a two-and-a-half-year period of operation based on conservative estimates of market penetration.

CONTRACT PROPOSAL DEVELOPMENT

The state requirements for the submission of a prepaid plan contract proposal are extensive and time-consuming. The process is a gradual one that allows the state to ensure that the provider is capable of meeting all contract requirements -- administrative, plan process, benefits, and case management. A network of subcontractor arrangements covering all services not provided directly by the plan must be formally negotiated prior to contract approval. State officials guarantee a 30-day turnaround for contract reviews.

CONTRACT EXECUTION

Once the proposal has been approved, the state and the contractor negotiate a legally binding contract.

ON-SITE IMPLEMENTATION REVIEW

A comprehensive on-site walk-through of all plan operations is conducted over a three-day period to ensure that all contract requirements have been met.

In organizing their development activities, AHP staff members focus on those geographic areas with the greatest number of Medicaid recipients and give priority in marketing the prepaid program to those providers perceived to be the most capable of implementing a prepaid plan. State officials do not believe that one type of provider is better suited for these activities than others. Nonetheless, based on current contract patterns, hospitals appear to have found it easier to develop prepaid programs with comprehensive service arrangements, and to assume financial risk.

When approaching individual providers, AHP staff work closely with local authorities, both locally-based state officials and representatives from local health departments. County-wide variations in population needs and provider resources make this type of consultation helpful.

The ultimate objective of the Alternative Health Plan Office is to create competition among Medicaid providers (the intent of the original HCFA-funded competitive bidding demonstration). Despite substantial provider interest, however, a truly competitive environment has not yet been achieved. Florida officials report being on "the brink of saturating" one small county where two provider groups could serve the entire Medicaid population. In this situation, state officials are considering requiring that all Medicaid recipients in the county enroll in one of the available prepaid plans.

C. ENROLLMENT/MARKETING

Recognizing the importance of marketing, AHP staff are willing to help plan contractors with their promotional efforts. Initially, all plan contractors receive detailed information on the number and

distribution of Medicaid recipients (by age/sex and by recipient category) according to zip code, as a means of focusing their marketing efforts.

The Medicaid Office has publicized the availability of the prepaid plans through posters and video screens at Food Stamp offices. In addition, Florida officials are willing to send out plan brochures to all Medicaid recipients in the monthly mailings that distribute Medicaid eligibility cards. Information regarding the plans has also been sent to area providers.

Beyond this assistance from the state, contracting plans are responsible for their own marketing. The aggressiveness of their efforts has varied with the scope of the Medicaid population they have sought to recruit. Those that seek only to retain market share have limited their marketing efforts to their current patients; others, by contrast, are planning county-wide recruitment efforts.

The categories of Medicaid recipients enrolled in the current prepaid plans vary, in part because some plans established prior to the Florida program had traditionally limited the scope of their enrollment. Three of the current contractors serve all four eligibility categories: AFDC/Foster Care, SSI/No Medicare, SSI/Medicare Part B, and SSI/Medicare Part A and B. Two contractors serve only AFDC recipients. In the near future, one new contractor is expected to cover all of the eligibility groups and another will serve AFDC recipients only.

D. SERVICES

The generic contract used by the Alternative Health Plan Office specifies the services all contractors are expected to provide.

Services include:

- Hospital Inpatient Services
- Hospital Outpatient Services
- Emergency Services
- Physician Services
- Prescribed Drug Services
- Advanced Registered Nurse Practitioner Services
- Laboratory and X-Ray Services
- Transportation Services
- Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)
- Family Planning Services
- Home Health Services
- Adult Visual, Dental, and Hearing Services
- Child Visual, Dental, and Hearing Services

Not all contractors are currently providing comprehensive services. One plan, for example, excludes dental care and transportation.

E. RATE REIMBURSEMENT/PAYMENT

The AHP Office has established composite rates based on the paid claims history for individual counties. The rates are calculated on the basis of past utilization of covered services, the cost per unit of service, and an inflation factor (the expected increase in the

cost per unit of service). Separate rates have been established for each of the four eligibility categories (AFDC/Foster Care, SSI/No Medicare, SSI/Medicare Part B, SSI/Medicare Part A and B.) The state is analyzing the development of age/sex rates and is looking at geographic areas larger than single counties to reduce wide variations in year-to-year experience.

The state's policy is to establish county-wide rates for participating plans (although one plan has been receiving a service area rate that is higher than the rate for the county in which the service area is located.) The ultimate goal is to set capitated rates at 95 percent of the existing fee-for-service rate. Because of wide variations in paid claims experience from year-to-year, the state has found it necessary in some instances to negotiate capitation rates greater or less than 95 percent of the fee-for-service rate.

A separate HMO subsystem is currently being set up in the Medicaid office. It will capture provider capitation rate history, enrollment data, payments to date, and service utilization information. Currently, however, plans submit their requests for payment by tape based on monthly enrollment figures. Exhibit 2 shows the enrollment report completed by the health plans as a basis for their monthly payments.

Prepaid contractors are totally "at risk" for the services required by their enrollees. A 45-day (per year) limit on Medicaid payments for hospital inpatient services reduces the plans' risk to some extent. As protection against catastrophic expenses, all plans are expected either to set up a risk reserve or to provide for reinsurance.

Catastrophic expenses are considered to be those incurred charges over \$10,000. When expenses are between \$10,000 and \$15,000, the plan can cover 75 percent of them from the reserve fund; 100 percent of the expenses can be drawn from the fund when they exceed \$15,000.

F. PLAN ADMINISTRATION/QUALITY CONTROL

An overview of the implementation, management, and monitoring process is displayed in Exhibit 3. The contract requirements that individual plans are expected to meet are very detailed. As shown in Exhibit 4, each component of plan operations is addressed, with the plans' responsibilities clearly delineated.

After a contract has been signed, additional time is devoted to ensuring that all of the state's implementation requirements have been met. Once the program has started, monthly administrative reviews monitor plan progress. Payment requests are compared against enrollment reports, and quarterly utilization reports and income statements are examined. The AHP staff supplements these efforts with periodic spot checks and conducts on-site reviews about six months after the plan has been in operation. The plans are also evaluated annually through medical audits and contract compliance reviews.

Quality assurance must be an ongoing part of the plan's program, with specifically designated quality assurance staff conducting quarterly reviews of a random selection of enrollee records. Criteria examined include diagnosis management, appropriateness and timeliness of care, comprehensiveness of and compliance with the plan of care, and evidence of special screening for high-risk individuals or conditions.

EXHIBIT 2
MEDICAID HMO MONTHLY ENROLLMENT REPORT

Plans are required to submit the following monthly computer report, listing every person who has been enrolled, disenrolled, or cancelled during the reported monthly period.

Patient's Last Name

Patient's First Name

Medicaid I.D. Number

Eligibility Source Code

Action Date

Action Code (e.g., Enrollment, Disenrollment, Cancellation)

Inpatient Days

Plan Number

Patient's Plan I.D. Number

Outpatient Dollars

Patient's Birthday

The state's fiscal agent then sends the plans hard copy printouts of the following tape generated reports:

- New Enrollee Report
- Cancellation Report
- Disenrollment Report
- Ongoing Report
- Error Control Edit Report

EXHIBIT 3
IMPLEMENTATION/RENEWAL SCHEDULE OF ACTIVITIES

1. CONTRACT NEGOTIATION
2. CONTRACT SIGNING
3. PRE-IMPLEMENTATION STAGE
 - Establish complete set of contract files for the plan
 - Obtain contractor's pre-implementation schedule and track progress
 - Complete any required systems modifications
4. IMPLEMENTATION PHASE
 - Conduct final on-site review
5. MONTHLY AND QUARTERLY ADMINISTRATIVE REVIEW
 - Review/intercept list/make corrections
 - Review/approve quarterly service utilization reports
 - Review payment request against ongoing enrollment report
6. ON-SITE MONITORING OF SPECIFIC CONTRACT ISSUES
 - Complete monitoring visit
 - Write monitoring report
 - If necessary, require corrective action
7. CORRECTIVE ACTION PHASE
 - Request corrective action plan from contractor
 - Ensure compliance
8. ANNUAL MEDICAL AUDIT
 - Schedule and conduct site visit
 - Assess results of medical audit
 - Prepare report of findings and recommendations. If necessary, require corrective action.
9. ANNUAL CONTRACT COMPLIANCE REVIEW
 - Schedule and conduct site visit
 - Complete compliance review checklist
 - Write compliance review report
 - If necessary, require corrective action.
10. CONTRACT RENEGOTIATION

EXHIBIT 4

CONTRACT REQUIREMENTS FLORIDA ALTERNATIVE HEALTH PLAN OFFICE

BENEFIT/SERVICE REQUIREMENTS

This part of the contract specifies the services the plan must provide, the required availability of these services, case management responsibilities, and provisions for out-of-plan use.

PERSONS ELIGIBLE FOR ENROLLMENT

Recipients eligible to enroll in the plans are defined.

MARKETING/ENROLLMENT/DISENROLLMENT

After defining the plan's market area, this part of the contract specifies marketing and enrollment procedures, and the specific requirements that apply in the case of disenrollment.

GRIEVANCE SYSTEM REQUIREMENTS

Plans are required to set up a formal grievance system, with a grievance coordinator and a process for receiving and resolving grievances.

ADMINISTRATION/MANAGEMENT

The proposal and the contract specify staff requirements, the features of the quality assurance programs that must be established (including peer review activities), and guidelines for fiscal management of the plans. The latter cover:

- Payment Procedures
- Rate Adjustments
- Risk Reserves
- Interest/Savings
- Third Party Resources

REPORTING REQUIREMENTS

Plans are required to submit information to the Alternative Health Plan Office on the following items:

- Enrollment/Disenrollment (Monthly Report)
- Service Utilization (Quarterly Report)
- Finances (Annual and Quarterly Report)

G. PROVIDER/CONSUMER RESPONSE

The Alternative Health Plan Office has stimulated a great deal of interest in the development of prepaid plans among a variety of providers. The status of the program at the current time is as follows:

- Five contractors are operating prepaid plans: four hospitals and one county health department.
- Two other contracts have been signed -- with a hospital and a physician clinic. These plans will become operational this fall.
- Proposals are expected from two health maintenance organizations, an agency on aging, and another hospital.
- Letters of intent have been received from 16 potential contractors: 7 hospitals, 3 health departments, 4 health centers/physician groups, 1 HMO, and 1 mental health center.

In general, the organizations that have implemented programs to date have been health care institutions with large Medicaid populations, typically located in Dade County.

Local physicians are described as being "steeped in tradition" and potentially unwilling to "make a change and accept prepaid assignment." Hence, all of the prepaid plans, to date, employ staff physicians; one, however, is currently recruiting a network of local physicians to share in the risk and the potential profits.

One of the obstacles for non-hospital organizations in developing prepaid plans is the necessity of establishing contracts with local hospitals. These arrangements tend to put the plans "even more at risk" unless controls over hospital utilization can be instituted. To assist plans in surmounting this problem, the AHP Office has agreed, in certain instances, to pay for hospital services at the regular Medicaid fee-for-service rate. The plan would still be at risk, since the cost of this hospitalization would be deducted from the next month's capitation payment. Nonetheless, for specialty services such as neonatal intensive care, the advantage of this option is that formal contract arrangements would not be necessary; when such services are required, they would be provided at the existing Medicaid rate.

To date, beneficiary response to the prepaid program is reported to be favorable. State officials report that "people went to [plan] providers anyway" and simply continue to do so under the prepaid arrangement. The plans are reinforcing these tendencies, since many of the traditional Medicaid providers are concentrating their enrollment efforts among current patients.

Some Medicaid recipients are reported to "know the game." One enrollee reportedly joined a plan because of its dental benefits, but then insisted on using an out-of-plan hospital when her child was sick. Other recipients do not fully understand their enrollment limits, and must be educated regarding plan restrictions. Plan disenrollment is said "not to be a big issue." The only complaints that have been received concern the need to "stand in line" for care at one facility.

Some have speculated that enrollment in prepaid plans is less attractive to potential enrollees if they believe that their use of pharmaceutical services may be restricted. Fee-for-service claims

for pharmaceutical services average \$21 per month, and anecdotal evidence suggests that recipients view this benefit as an entitlement.

Pharmaceutical services represent a \$100 million program in Florida. Some local pharmacies specialize in serving the Medicaid population and, consequently, have large annual Medicaid billings. Because of political pressures, the AHP Office has agreed to reimburse pharmacists in one community at Medicaid fee-for-service rates for those plan enrollees who choose not to use the plan pharmacy. (Approximately two-thirds of the plan enrollees stay with the plan pharmacy.) The plan is still at risk for pharmacy services, and these expenditures are deducted from the next monthly payment.

The biggest problem from the plans' perspective is turnover in recipient eligibility. State officials report that in any given month enrollments tend to equal disenrollments, with disenrollments resulting largely from recipients losing their eligibility. In order to help plans to grow, the AHP Office is now instituting a system whereby plan enrollees would automatically be reenrolled in their prepaid plan if they choose once their eligibility has been reestablished. This is expected to diminish plan turnover by about 20 percent.

Evaluation of Medicaid Competition Demonstrations

Volume V

The Minnesota Prepaid Medicaid Demonstration

by

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CHAPTER ONE

INTRODUCTION

The Medicaid demonstration in Minnesota is now partially operational in three counties. Its stated objectives are to:

- control public expenditures by generating more efficient use of medical resources rather than through program cutbacks;
- promote the further evolution of a competitive health care marketplace; and
- test policies and procedures that might be part of a national prepaid Medicaid program.

The largest scale programs are in two counties in the Minneapolis-St. Paul ("Twin Cities") area -- in Hennepin County, which includes the city of Minneapolis, and in Dakota County, a suburban county just south of St. Paul. Enrollment was initiated in December 1985. In Dakota County, most of the Medicaid population will ultimately be required to enroll in a prepaid health plan, otherwise known as a Medicaid Health Plan (MHP). In Hennepin County, 35 percent of the identified Medicaid groups, which includes most of the Aged, Blind, and Disabled as well as the AFDC population, will be randomly assigned to the program and will have to elect from among the participating MHPs; the remaining 65 percent will retain the fee-for-service option, creating a control population.

The third demonstration county is Itasca, in a rural area in the central part of the state. There, since July 1985, the county itself has been treated as an MHP. It thus has accepted the risk for most Medicaid beneficiaries, although it transfers much of this risk to participating providers.

This report represents the second in a series of case studies on the demonstration in Minnesota. The first one was written in April 1984 and reflected field work that was performed the previous December. It focused

exclusively on the Twin Cities where the demonstration was slated to begin in July 1984 and chronicled the health care market locally, the decision making process, the reactions of the organizations that would likely submit bids to become MHPs, and provider and consumer reactions. It also presented a series of issues that the demonstration raised. Some of the key findings of that report were the following:

- The Twin Cities has long been a hotbed of HMO development, with some 30 percent of the population enrolled in prepaid plans at the time, possibly reflecting the longstanding presence and acceptance of multispecialty group practice. However, the major untapped market has been Medicaid.
- The intent of the state was to conduct a demonstration in three counties. The most important site would be one of the two urban counties, Ramsey and Hennepin. When Ramsey County (which includes the city of St. Paul) declined at an early stage to participate, the state focused on Hennepin. A second county was to be suburban. Also, Itasca County in northern Minnesota volunteered at an early stage to participate as the rural site.
- In the urban (Hennepin) and suburban (now Dakota) counties, beneficiaries were to be required to enroll in one of several approved MHPs, and those failing to do so would be assigned. The plans were to be paid 90 percent of projected fee-for-service expenditures for AFDC enrollees and 95 percent for the Aged, Blind, and Disabled. In Itasca County, the county itself would receive 90 and 95 percent, respectively. However, the plans (including Itasca) were protected through various reinsurance and risk sharing provisions.
- Eligibility in Minnesota is determined by the counties, which bear the administrative costs of the eligibility determination and 10 percent of the state's share of benefit payments.

- The Medicaid benefits are very comprehensive, limiting opportunities for the plans to cover additional services. Also, skilled nursing facility (SNF) and intermediate care facility (ICF) services account for a high -- some two-thirds -- proportion of the Medicaid budget, and the state continues to pay for most of these services directly rather than placing the MHPs at risk. Finally, providers, and notably physician, participation in the Medicaid program is widespread.
- The development of the demonstration entailed a time-consuming planning and consensus building process that included the participation of representatives of plans, provider groups, and consumer advocacy groups in addition to the participation of two legislators and executive branch staff.

As is apparent, the initiation date was delayed significantly, and, as might be expected, aspects of the demonstration have changed, although the approach is not fundamentally different from that originally envisaged. This report discusses events over the last two years and, particularly, the early stages of implementation. It reflects mostly a four-day site visit conducted by the two authors in April 1986 as well as subsequent telephone interviews.

The report has five additional chapters: Chapter II provides an overview of the demonstration in the Twin Cities, including a brief history of how Hennepin County came to participate in the project. Chapter III discusses implementation issues such as rate setting, enrollment, reporting, and the role of the counties in administering the project. Chapter IV describes the seven participating MHPs and relays some of their experiences with the demonstration to date, while Chapter V offers the perspective of consumers and providers. Chapter VI describes the demonstration in Itasca County. Chapter VII summarizes some of the policy and implementation issues that the demonstration raises.

CHAPTER TWO

OVERVIEW OF THE DEMONSTRATION IN THE TWIN CITIES

A. INTRODUCTION

This chapter provides an overview of the demonstration in the two Twin Cities counties participating in the demonstration. The next section briefly traces the evolution of the marketplace in the last few years. Then, the history of the demonstration since April 1984 is summarized, with particular attention to the difficulties that arose in obtaining Hennepin County's participation. The final section describes the program as it now stands.

B. DEVELOPMENTS IN THE HEALTH CARE MARKETPLACE

The Twin Cities marketplace continues to evolve as one with excess capacity and considerable competition, particularly among the large HMOs and PPOs, each of which command a significant share of the market. According to the American Hospital Association, the Twin Cities Metropolitan Statistical Area, defined by the U.S. Census to encompass 10 counties, had an occupancy rate of 69 percent in 1983 compared to the national average of 76 percent. However, hospital utilization in the last several years has declined dramatically, and occupancy in the Twin Cities is now below 50 percent of licensed bed capacity.

Physicians are also in oversupply. According to the American Medical Association, in 1983 there were 243 physicians per 100,000 population in the MSA and 355 in Hennepin County, compared to the national average of 194. These excesses are compounded by the high HMO penetration, discussed below. HMOs use between 100 and 110 physicians per 100,000 enrollees. As HMO enrollment increases, those physicians with substantial fee-for-service practices find themselves competing for dwindling numbers of patients.

HMOs have, indeed, grown, and some 40 percent of the population is now enrolled, compared to just over 20 percent some four years ago. By one

estimate, some 28 percent of the elderly are enrolled in HMOs with Medicare risk contracts (none were enrolled four years ago), and among employees of some private corporations, such as Honeywell and General Mills, penetration exceeds 75 percent. Furthermore, these statistics do not reflect the substantial success of the Blue Cross/Blue Shield PPO arrangements, Aware and Aware Gold, both of which are managed care programs with mandatory hospital preadmission and concurrent review. Altogether, membership in alternative delivery systems, or managed care plans, now exceeds 50 percent of the total population. The most notable exception is the Medicaid population, only small numbers of whom enrolled in HMOs under the state's voluntary program that has existed since 1977.

Structural changes are also occurring locally in the HMO industry. There were two HMO consolidations last year, the largest of which entailed the merger of two multi-state for-profit HMO companies headquartered in the Twin Cities, with United HealthCare Corporation acquiring Share Development Corporation. Each company manages a large HMO locally.* The resulting merger makes United the largest for-profit HMO company in the country, with more than one million members in plans that it owns or manages. The second consolidation occurred when HMO Minnesota, the Blues' HMO (70,000 enrollees) took over the management of Coordinated Health Care, a 20,000 member plan.

Another structural change is in the nature of the benefit programs, with all of the plans moving beyond the pure HMO to HMO-PPO hybrids that pay for use of services by nonparticipating providers. Under these hybrid arrangements, which take various forms, the enrollee may elect to use nonparticipating providers but faces higher cost sharing if he or she does. The Aware Gold program of the "Blues" has adopted a three-tier cost sharing structure depending on whether the enrollee uses (1) an HMO Minnesota provider, (2) a provider who participates in Blue Cross/Blue Shield but not in HMO Minnesota, or (3) a provider who does not participate in either.

* SHARE Development Company manages SHARE of Minnesota with 131,000 members, and United manages Physicians Health Plan with 306,000 members. In both instances, the senior staff of the management company got their start at the two HMOs, which remain nonprofit as required by state law, and subsequently spun off the for-profit management companies.

C. HISTORY OF DEMONSTRATION SINCE APRIL 1984

The roughly year-and-a-half delay in the start of the program was due principally to the problems of securing the participation of one of the two Twin Cities counties, most notably Hennepin County, since Ramsey had declined at an early stage to participate. Hennepin had expressed some interest in the program but also raised a number of concerns. County officials were skeptical about the demonstration project primarily in terms of (1) its impact on the county and (2) the state's ability to implement the project successfully.

The county foresaw potential negative impacts on county finances and on service delivery. Its major financial concerns included the following:

- Impact on Hennepin County Medical Center (HCMC). HCMC is a major tertiary care resource for the community that receives about 25 percent of its revenues from Medicaid. First, the medical center could lose volume because patients join plans that contract with other facilities. Second, the medical center has high costs, a characteristic that its administration attributes to its role in medical education and research and the severity of its case mix. Thus, the hospital could suffer in an environment where prices were set competitively. Third, adverse selection was feared because of the high (or at least so it was claimed) proportion of very sick patients who use HCMC as their usual source of care.
- The cost of administering the program, which the county feared could exceed its share of the projected savings from the demonstration. Under the regular Medicaid program, the county is responsible for Medicaid enrollment and bears the associated administrative costs. It also reimburses the state for 10 percent of state's share of the cost of benefit payments. Under the demonstration, the state had proposed reducing the match to 5 percent and reimbursing administrative expenses attributable to the demonstration, thereby benefiting the county. However, the county argued that it would face expenses under the demonstration that the state had not recognized.

- Continued use of county providers by demonstration enrollees, since MHPs could avoid providing physical and/or mental health services by referring patients to county-funded sliding fee scale providers, who would in turn request more county funding to accommodate increased demand.

Service delivery or client care concerns included:

- The inability of clients to make effective choices. The Medicaid population includes clients (e.g., aged, physically disabled, mentally impaired) who may not be able to choose MHPs for themselves or be assertive enough to complain if the services they receive are inappropriate.
- Client choice of providers limited to those affiliated with an MHP. As a result, some providers producing favorable outcomes for clients in the current system would be less accessible in the demonstration (e.g., mental health and chemical dependency providers).
- Disruption of existing provider relationships, which occurs when clients find their various providers belong to different MHPs or are not affiliated with MHPs.
- Potential for underservice, particularly when client needs (and costs) exceed what the MHP receives in payment. County social workers, in particular, questioned whether HMOs in the demonstration would provide adequate services to the chronically mentally ill.

In addition to questions about the demonstration's impact on the county in terms of financing and service delivery, the state's ability to implement the demonstration successfully was also questioned. The state's implementation schedule was viewed as unrealistic, a perspective that to date has proven accurate. The county also expressed concern about inadequate staffing by the state to operate the project and about the obsolete Medicaid computer system.

Hennepin County's approach to dealing with the demonstration project in the end resulted in as favorable an outcome for the county as could be expected. Because of its ambivalence about the project, it was politically advantageous to distance the county from the project in the public's mind. Thus, the full responsibility for any problems that ensued would fall on the state. There were three stages to the county deliberations on the project.

First, in 1983 a research paper was prepared by county planning staff outlining the issues that the proposed demonstration raised. Next, public hearings were held, with considerable participation from advocacy groups. Third, a task force of high level staff was convened in September 1984 to devise an implementation plan in the event that the demonstration was approved by the county commissioners. The resulting document, A Plan for a Medicaid Demonstration Project in Hennepin County, prepared in January 1985, was relied on by the county in reviewing the project and eventually by the state and HCFA in the development of its protocol and the issuance of federal waivers.

Although the county commissioners recognized some potential advantages of the demonstration, such as a more predictable Medicaid budget and an opportunity for HCMC to obtain experience with prepayment, they believed on balance that the potential negative impact outweighed the advantages. Thus, in March 1985 they voted five-to-two to stay out of the demonstration. Shortly thereafter, however, the state mandated participation by Hennepin County. Because the county would be forced to participate anyway, the commissioners reversed themselves, in order to obtain concessions agreed to by the state. They passed a resolution in early May 1985 approving the demonstration and accepting the task force's document as the protocol. The resolution was conditional, with 21 conditions the state was asked to meet. Some of the more significant were the following:

- The state would agree to pay all county administrative costs for the management and oversight of the project.

- MHPs would be reimbursed for direct and indirect costs associated with medical education.*
- The demonstration would be limited to 35 percent of the county's AFDC, Blind/Disabled, and Aged clients.
- HCMC would be one of the MHPs and would serve all three client groups.

For the most part, these conditions have been met by the state, even though technically the county had little leverage. If the county had not passed the resolution, or if it withdrew its approval because certain conditions were not met, the state could have forced -- and still could force -- the county to participate without granting any concessions. Although the county is technically the agent of the state for Medicaid, as an independent political entity, it has greater negotiating power than is typical in a vendor relationship.

In November 1985, the first 99 AFDC beneficiaries enrolled in the program and began receiving services December 1986. As of July 1, 1986, about 8,500 clients had been through the enrollment process in Hennepin and Dakota counties, and cumulative enrollment (including disenrollments) had reached 8,067, considerably fewer than originally intended. Noninstitutionalized Aged, Blind, and Disabled (ABD) beneficiaries were slated to begin enrollment in June, but this date has been postponed until late summer or early fall (Table II-1 presents enrollment by MHP).

* Direct costs include the cost of interns, residents, and supervisory time; indirect costs are an estimate of the additional expenses borne by a hospital because of its teaching load (e.g., laboratory tests performed primarily for didactic purposes). The state has decided to employ the methodology employed by Medicare's prospective payment system for hospitals, but is still working out details of implementation.

TABLE II-1

MHP ENROLLMENT -- HENNEPIN AND DAKOTA COUNTIES*

JULY 1, 1986

Blue Cross and Blue Shield	2,151
Group Health, Inc.	718
MedCenters	835
Metropolitan Health Plan	641
Physicians Health Plan	2,913
PreferredOne	489
U-Care Minnesota	<u>320</u>
Total	8,067

* Figures are cumulative and include disenrollment.

D. PROGRAM DESCRIPTION

Unlike most programs and demonstrations in other states, the Minnesota demonstration includes the Aged, Blind, and Disabled populations. Ideally, the state would have preferred to cover all populations for all services, but instead it has excluded (1) most nursing home costs and (2) selected eligibility groups for whom capitation was considered inappropriate.

First, most nursing home costs (both SNF and ICF) are excluded from the capitation payment and, instead, are paid by the state as a pass-through for populations who are institutionalized at the time they enter the program. For populations who enter a nursing home after enrolling in an MHP, the plan is fully at risk for only the first 90 days of care during a fiscal year (which may be accumulated from multiple stays) or for 90 consecutive days that span two fiscal years. After the 90 days, the state pays 80 percent of the cost, and the plan is liable for the remaining 20 percent.

Additionally, certain populations are excluded from the demonstration altogether. Most notable are the six-month spend-down recipients, both those in institutions and those not. This group consists of spend-down recipients who are expected to be eligible for Medicaid for only a brief period of time and thus is not judged suitable for capitation. Other excluded groups are:

- Residents of state hospitals -- because the costs are largely set through the state's budgeting process for these hospitals.
- Individuals in the personal care attendant program -- a small group of only 175 in the seven-county metropolitan area whose costs vary widely.
- Refugees -- because of federal refugee assistance covering this group and because it was felt best not to impose on the refugees or the MHPs the additional burden of having to deal with language problems and other cultural differences.

In addition, three other groups have been excluded for the first year of the project but may be included in future years. These include: certain AFDC foster children, subsidized adoption cases, and needy children (children who receive Medical Assistance but whose parents are not eligible for AFDC or Medicaid).

In Dakota County, all of the covered populations must enroll in an MHP or they will be assigned. In Hennepin County, 35 percent of the population is randomly selected and required to enroll. The remaining 65 percent may remain in the fee-for-service sector, although they may also enroll voluntarily in HMOs that entered into Medicaid contracts prior to the demonstration. The random selection of clients for participation in the demonstration is based on the last two digits of the beneficiary's Medicaid identification number. The decision to restrict the mandatory feature of the program to 35 percent was made to enable the state and county to assess the program, and the county has awarded let a state-funded contract to the Center for Health Services Research at the University of Minnesota School of Public Health to perform an independent evaluation.

The state's RFP was released in early May 1985, with the deadline for responses July 16, 1985. All told, nine plans submitted bids to become MHPs, and seven ultimately received contracts. One of those that did not was Senior Health Plan, a nonprofit organization formed by a consortium formed several years ago that consists of (1) the Wilder Foundation, the second largest operating foundation in the U.S., which provides services to the elderly, the poor, and children; (2) Health Central, a large health care system headquartered in the Twin Cities; and (3) St. Paul-Ramsey Medical Center. Senior Health Plan, which had intended to serve the elderly only, withdrew because it was concerned about ultimately being able to meet requirements that HMOs and other prepaid health plans have significant levels of private enrollment (i.e., other than Medicare or Medicaid), as defined in federal statutes.

The second was the Plymouth Avenue Clinic, which is owned by a group of black physicians. It was rejected for quality of care reasons and questions

regarding its ability to bear financial risk. That rejection became a political issue and included charges of racism. State representatives commented that having reasonably objective criteria for plan selection became important in their ability to sustain the denial.

All of the seven plans that were selected are delivering services in Hennepin County, and five of these are doing so in Dakota County. These seven plans are:

- Blue Cross and Blue Shield of Minnesota (the "Sun Series" program).
- Group Health, Inc., a large nonprofit staff model HMO with 214,000 members.
- MedCenters Health Plan, a network model HMO with 213,000 enrollees that evolved from the Park Nicollet Clinic, a large multispecialty group practice.
- Metropolitan Health Plan, which was formed by the Hennepin County Bureau of Health to attract AFDC clients under the voluntary HMO program.
- Physicians Health Plan of Minnesota, a broad-based IPA with 306,000 members that developed as a competitive response to other Twin Cities HMO activity.
- PreferredOne, a PPO operated by HealthOne, a multihospital system.
- U-Care Minnesota, which is not a licensed HMO, operated by University Affiliated Family Physicians at the University of Minnesota.

The two plans that do not serve beneficiaries in Dakota County are Metropolitan and U-Care.

One of the conditions of participation was that the MHPs serve either the Aged or the Blind/Disabled populations, i.e., they could not serve only AFDC recipients. The state imposed this requirement because it felt that one of the major innovations of the demonstration was capitating populations other than AFDC. As it turned out, all plans are enrolling AFDC and Aged beneficiaries, but only four are enrolling the Blind and Disabled (Blue Cross/Blue Shield, Metropolitan, PreferredOne, and U-Care). State representatives expressed disappointment that more plans are not serving the Blind and Disabled, particularly as only two MHPs (Blue Cross/Blue Shield and PreferredOne), neither of which are HMOs, have agreed to enroll those populations in Dakota County.*

* As described in Chapter IV, Blue Cross/Blue Shield elected to establish a new program for the Medicaid population rather than have HMO Minnesota, its HMO, participate.

CHAPTER THREE

STATE/COUNTY IMPLEMENTATION ISSUES

A. INTRODUCTION

Issues of the state's and county's administration of the demonstration are woven throughout this report, with a focus on those concerning MHP relations in particular in Chapter IV. This chapter discusses selected aspects of the administration of the program and some of the political ramifications. The specific topics discussed are:

- payment policies,
- enrollment,
- MHP data reporting requirements,
- the role of the county,
- the ramifications of the demonstration on the Medicaid program as a whole.

B. PAYMENT POLICIES

The MHPs are paid capitation rates, which are intended to be set at:

- 90 percent of what would have been spent under the fee-for-service system for the AFDC population and
- 95 percent for the aged, blind, and disabled.

However, the state has also reduced the risk in several ways. This section describes (1) the nature of the risk limitations, (2) the methodology for setting the capitation rates for those services for which the plan is at risk, and (3) issues associated with the rate setting methodology. Subsections (1) and (2) are largely based on the Lewin and Associates April 1984 case study and the state's March 13, 1985, Implementation Protocol.

1. Risk Limitations

The risk borne by the plans is mitigated in three ways. First, routine nursing home costs are excluded for recipients who reside in nursing homes at the time they either first enter the demonstration or initially become eligible for Medicaid. However, other costs -- such as drugs, physician services, and ancillary services -- are capitated. The effect of this exclusion is to keep almost two-thirds of the Medicaid budget for populations that are part of the demonstration.

Second, there are stop-loss, or reinsurance, provisions that are triggered for any individual recipient under the following circumstances:

- For hospital services: When cumulative annual expenses (based on Medicaid allowable charges) exceed the \$15,000 for AFDC recipients and \$30,000 for other Medicaid groups.
- For nursing home services, other than for persons who are institutionalized when they enter the program: After 90 days of care within a fiscal year (which may be accumulated from multiple stays) or for 90 consecutive days that span two fiscal years.

Above these trigger points, the state will pay 80 percent of the cost, and the plan is liable for the remaining 20 percent. A plan may elect not to participate in the stop-loss program in return for higher capitation payments provided that: (1) it has adequate financial reserves separate from operating funds to cover catastrophic liabilities, (2) not more than 30 percent of its revenues are from Medicaid, and (3) it agrees to provide the state with 180 days notice if it wishes to terminate the contract with the state, as opposed to 90 days notice if it does participate in the stop-loss program.

Third, there is an aggregate risk-sharing provision that operates for the first two years of the demonstration only:

- For AFDC populations, who are capitated at 90 percent of estimated fee-for-service, the state will share 50 percent of the losses the

first year if the plan's actual costs are between 90 and 110 percent of fee-for-service. Above 110 percent, the plan is fully at risk. In the second year, the state will share half of the loss between 90 and 100 percent only (rather than between 90 and 110).

- For the Aged, Blind, or Disabled, who are capitated at 95 percent of estimated fee-for-service, the state will share half of the loss between 95 and 115 percent in the first year, and half the loss between 95 and 105 percent in the second year.

After the second year, there is no aggregate risk-sharing, and the plans are fully at risk. Unlike the two stop-loss provisions limitations described above, capitation rates to the plans are not reduced to account for any costs that result from the aggregate risk-sharing provisions. However, the formula is designed in such a way that a plan can never receive more than 100 percent of fee-for-service for the AFDC population or 105 percent for other Medicaid groups in the first year. After the first year, there will be no payments above 100 percent of fee-for-service for any group.

2. Rate Setting Methodology

The base years for rate setting purposes are FY 1982 for Hennepin and Itasca Counties and FY 1983 for Dakota County. Once established, the rates are trended forward to the years during which the program is operational. For the base years, a series of rate cells were first defined, and the monthly costs per recipient calculated for each of the rate cells in each of the seven counties in the metropolitan area. These rate cells are essentially cross-tabulations based on (1) county of residence, (2) Medicaid eligibility category, (3) sex, (4) age (broken into eleven cohorts), (5) institutional setting (i.e., not in institution, nursing home resident, and ICF-MR resident), and (6) whether or not the recipient is also on Medicare.

Then, the effect of the stop-loss provisions described above, except for the two-year aggregate risk-sharing provision, was calculated for each rate cell and subtracted from the cost base.

Next, in situations where the resulting combination was logical, many of the rate cells were aggregated based on homogeneity in the rates, meaning that the rates did not differ significantly from one another. This reduced the number of rate cells to 77 from a potential of 264.

The average cost for each county and each rate cell was then calculated. If the sample size within a rate cell was sufficient, that average was used. If not, one of two approaches was adopted:

1. If the individual cells were small, but the total population in that category was large, the seven-county distribution was reproduced, adjusting for the age/sex variation of the specific county.
2. If the total population in a category was small, the seven-county metropolitan averages were used.

The aggregate expenditures within a county resulting from these rates were intended to equal actual Medicaid expenditures in the base year. Therefore, after determining the payment amounts for the individual rate cells, the aggregate expenditures that would result were calculated, and a proportionate adjustment was made across the board to reproduce the 1982 or 1983 actual experience. This adjustment was a small one.

The rates in each cell were trended forward from FY 1982 to FY 1985, the original implementation year. These adjustments were 13.9 percent for all noninstitutional service categories and 15.2 percent for all institutional service categories. (Since FY 1983 was used as a base year for Dakota County, only two-thirds of the above amounts were used, yielding adjustment factors of 9.27 percent and 10.13 percent, respectively.) These figures were derived by using state forecasted figures for increases in Medicaid expenditures, which the state has developed for budgeting purposes. Because implementation has been delayed until FY 1986, rates were brought forward to FY 1986 using the legislatively allowable increase of 5 percent. Finally, the 90 percent payment level for AFDC beneficiaries, and 95 percent for Aged, Blind, and Disabled was calculated.

3. Rate Setting Issues

The methodology overall is generally viewed as sound. In addition, MHPs that have examined the rates for groups for which they have comparable populations, mostly AFDC enrollees, find those rates to be reasonable. The involvement of Harry Sutton, a highly respected HMO actuary with Towers, Perrin, Forster, and Crosby, a benefits consulting firm, helped legitimize the methodology among the MHPs. Nonetheless, a number of issues have arisen.

While the calculation of the base rates for 1982 and 1983 is generally accepted, the trending factors have been questioned. Most notably, for FY 1985 and FY 1986, the legislature enacted a provision limiting the increase in Medicaid reimbursement levels to 5 percent annually per item of service, a ceiling that has also been applied to the demonstration. However, under the demonstration the unit of payment is the total provision of care paid for by capitation. In contrast, under fee-for-service it is a specific item of service, with no limitation on the volume or intensity of services provided. Thus, reimbursement under the demonstration would be subject to constraints that are not applied to the fee-for-service system if volume or intensity per capita increases under fee-for-service as it has done historically.

Another issue relates to the incorporation of a health status adjustment that would reflect differences in health status within the 77 rate cells. Such an adjustment is intended to prevent what is commonly referred to as adverse or biased selection, i.e., the potential tendency of high risk beneficiaries to enroll in certain plans. The state in 1983 awarded a contract to an outside organization (On Lok in San Francisco) to develop a health status adjustment, but has since decided to work on the problem internally. The Medicaid program still hopes to incorporate a health status adjustment, but preliminary efforts have not yet produced a fully satisfactory approach.

One particular adverse selection issue relates to women who become eligible for Medicaid after they are pregnant, commonly late in the pregnancy. A significant percent of these women are believed to lose eligibility within a few months of delivering. As a result, they are members of an MHP for a brief

period only, during which time they generate high expenses. This situation would not be problematic were these women proportionately distributed among the participating plans. However, there is the concern that they tend to enroll in MHPs with broad physician participation, specifically, Blue Cross and PHP, and also the plan sponsored by the Hennepin County Bureau of Health.

Beneficiaries who are eligible for both Medicare and Medicaid pose problems. The rate setting methodology reflects the fee-for-service experience of those with dual eligibility. For these persons, Medicare is the primary payer and Medicaid is secondary, meaning that it is liable only for Medicaid-covered expenses that Medicare does not pay. For dual eligibles who elect the same plan for both Medicare and Medicaid, the plan receives a windfall. This arises because the federal government (under the federal HMO and Competitive Medical Plan legal authority enacted in 1982) pays the plans 95 percent of estimated Medicare fee-for-service amounts. This payment level is by legislative intent sufficient to allow the plan to cover the cost of some additional benefits, such as by absorbing the standard Medicare copayments. Thus, those not eligible for Medicaid have their out-of-pocket costs reduced because of the better coverage in the HMO. However, for beneficiaries who are on Medicaid, the reimbursement methodology of the demonstration in effect allows the plan to retain those savings because both the Medicare and Medicaid reimbursement to the HMO reflect the fee-for-service experience. The state is working on an adjustment to the capitation rate for dual eligibles.

Another anomaly exists for beneficiaries who elect different plans under the two programs, which is permitted. Only three of the MHPs -- Group Health, MedCenters, and PHP -- have Medicare risk contracts, and SHARE, a Minneapolis-based HMO with 36,000 Medicare enrollees, elected not to participate in the demonstration. Thus, a beneficiary with dual coverage could elect SHARE (or another plan with a Medicare but not a Medicaid contract) for Medicare and a participating MHP for Medicaid. That beneficiary would presumably use the MHP because of the more comprehensive coverage of Medicaid compared to Medicare. In such cases, the MHP incurs high expenses, and the plan that the beneficiary elected for his or her Medicare benefits receives a windfall.

Another rate setting issue, albeit one of less consequence than those discussed above, relates to the institutionalized patient on whose behalf state reimburses the nursing home directly. For a limited number of services, such as transportation and physical therapy, some nursing homes incorporate the costs into the per diem, whereas others bill separately. This disparity creates some confusion and reimbursement inequities in terms of the MHP's liabilities.

Finally, the time lag between when a beneficiary becomes eligible for Medicaid and when he or she enrolls in an MHP may create some distortions. That lag is, typically, of three to four months duration, during which period the beneficiary receives services from the fee-for-service system. The rate setting issue arises because it is likely that beneficiaries use services at a higher rate during the initial months of eligibility, particularly as their need for immediate medical care may be a reason for seeking Medicaid coverage in the first place.

C. ENROLLMENT

As of July 1, 1986, 8,067 beneficiaries had enrolled in MHPs, representing approximately 7,525 of 28,000 AFDC recipients and 542 of 2,300 non-AFDC nursing home residents.* Enrollment of noninstitutionalized Aged, Blind, and Disabled populations had not yet begun. Enrollment is scheduled to be completed in December 1986, with a total of approximately 34,000 Medicaid beneficiaries enrolled. About 27,000 of these will be in Hennepin and 7,000 in Dakota.

This section discusses (1) client education and the role of the broker, (2) the enrollment process, and (3) enrollment results.

* As described earlier, the MHPs are not at risk for most routine room and board nursing home expenditures but are at risk for other services, such as physician, ancillary, and hospital services.

1. Client Education and the Role of the Broker

The state contracted with the Minnesota Institute for Public Health to conduct health plan enrollment and act as a broker between enrollees and the MHPs. The Minnesota Institute of Public Health is a nonprofit firm specializing in marketing public programs. It created a new division, called the Health Plan Information Center (HPIC), specifically to serve the needs of the Medicaid demonstration project.

HPIC's role is to educate clients about the various MHPs in an unbiased manner and allow them to make an informed selection. The theme of all HPIC's educational efforts is "choice." However, when multiple attempts to reach a client and educate him or her to choose a plan do not result in the election of a health plan, HPIC randomly assigns beneficiaries to one of the seven MHPs. Clients then have 60 days to change plans.

Enrollment of both current and newly eligible Medicaid beneficiaries began in November 1985 according to a process agreed upon by HPIC and the state. Each month, the state sends HPIC a list of Medicaid recipients to be enrolled.* Next, the state mails out a letter to clients describing the change in Medicaid and introducing HPIC. HPIC then sends a letter and an invitation to one of several informational meetings. "Choice" packages with more detailed information about the demonstration are distributed at these client presentations or, upon request, are mailed to beneficiaries (new eligibles receive the package at intake). The Choice package contains a two-page brochure from each of the MHPs, an enrollment form, and other information for the client such as whom to call with questions and how the program differs from the old Medical Assistance. From this point, recipients have 45 days to select an MHP.

HPIC holds informational meetings during that 45-day period. Each client is notified of presentation times and locations and is strongly encour-

* The list is generated from a joint state/county computer file reflecting county eligibility determinations.

aged to attend. In addition, clients receive a postage-paid card allowing them to request special assistance at the presentation they plan to attend (e.g., an interpreter or help for the hearing impaired). Follow-up calls are made to encourage clients to attend and to reschedule those who missed presentations. In the past, HPIC has made up to seven attempts to reach clients, a highly time-consuming process.

Most clients who attend presentations do elect an MHP, usually while on-site, indicating that the seven part-time trained presenters are conveying the intended message. The presentations are standardized using a three-pronged approach -- a videotape, an oral presentation, and written handouts. However, low attendance at early presentations (sometimes only one or two clients out of 15-20 invited) resulted in a high rate of random assignment of beneficiaries failing to elect an MHP.

In response, HPIC tried to modify the process of contacting and enrolling beneficiaries. First, it developed a more attention-getting letter to accompany the Choice package. The new letter has a large red stop-sign on it and the statement "PLEASE READ THIS NOW" in bold lettering. Second, HPIC began to conduct follow-up telephone calls after the letter and package were mailed out to reinforce the importance of attending a meeting. Third, HPIC has asked advocacy organizations for assistance in publicizing the project and reaching clients with special needs. These steps have increased attendance but have not totally overcome the problem.

Some other problems affecting the enrollment process are more difficult for HPIC to solve, largely because they are under the state's control:

- Unresolved policy issues have been a problem for HPIC, as they have been for the MHPs (see Chapter IV). HPIC is out in front dealing with clients and often finds it does not have answers for the special or new issues that arise, because policy is being made as the project progresses.
- Timing is a major problem, in large part because the state has trouble pulling client lists off its computer each month on time.

The lists are often late getting to the broker, which creates problems because of the multi-step cycle that is followed for each client wave. For example, the state took three months to generate a list of Medicaid beneficiaries living in nursing homes.

- The provider directory, which was promised for November 1, 1985, was not completed by the state until last April 1. The directory allows HPIC to tell clients which MHPs their providers are affiliated with, an essential component of choice. The delay made it difficult for HPIC to be as helpful as it could have been. As it turns out, the provider directory quickly becomes out of date and the state has trouble keeping it current, in part because the MHPs are slow to update the state on their changing physician affiliations.
- Inadequate education (or inadequate absorption of educational efforts) in the provider community has resulted in HPIC having to inform health care providers about the demonstration as well. Administrators of nursing homes, advocacy groups, and so on often contact HPIC for information about policy changes and how they will be affected.
- The lack of media attention has limited HPIC's ability to educate beneficiaries. The state has asked HPIC not to use the media to explain the demonstration because it is concerned about (a) confusing the 65 percent of recipients in Hennepin County who are not part of the project and (b) interfering with the evaluation. As a result, HPIC's job is more difficult because it requires one-on-one effort.

2. Enrollment Process

When a Medicaid client selects an MHP, the enrollment form is completed and either mailed to HPIC or collected at a HPIC presentation. For clients to be enrolled as of the first of the month, HPIC must receive the form by about the 20th of the previous month. HPIC enters the data onto its computer and

then provides the information to the county. The county in turn enters the data into its computer file and verifies eligibility. The state accesses this information on about the sixth to the last working day of the month and mails lists of enrollees to each of the MHPs. The lists are supposed to be received by the MHPs five working days before the end of the month, although so far the deadline has rarely been met. This timeframe is intended to allow the MHPs to mail out identification cards so new members receive them by the first of the next month. In addition to the official monthly list of new enrollees, the MHPs receive unofficial weekly updates from the state telling them who enrolled the previous week.

In actuality, during the first six months of the demonstration, many clients did not receive identification cards by the first of the month, and consequently they continued to see fee-for-service providers. In June, for example, identification cards were mailed out by the seven MHPs from May 30 to June 10, meaning that clients probably received them from June 2 to June 13. The state typically is slow in generating enrollee lists for the MHPs because of its antiquated computer; it usually does not mail the lists out until two or three days before the end of the month. Some MHPs took the initiative to pick up the lists themselves or to pay for courier service, but others rebelled against this and insisted that the state must assume the responsibility of meeting its deadline. In June the state decided to make it a policy to deliver the monthly enrollment lists to the MHPs by courier. It also changed the timing of the MHP enrollment reports so that they are now run by the state's computer before other regular monthly reports, thus reducing the chance for delays.

3. Enrollment Results

A total of only 8,542 beneficiaries from Hennepin and Dakota counties went through the enrollment process between December 1985 and June 1986 (see Table III-1). Thus, early enrollment ran considerably behind the 2,100 projected monthly figure. However, the numbers enrolled grew each month as the system became more refined and problems were resolved, so that in July

HPIC enrolled over 4,000 clients (including those who failed to choose MHPs and were randomly assigned). The major reason for the slow start was the state's computer system, which broke down at critical points and was unable to generate in a timely fashion lists of clients for HPIC to contact.

TABLE III-1

MONTHLY ENROLLMENT OF MEDICAID
BENEFICIARIES IN MHPs

December 1985	99
January 1986	405
February	538
March	370
April	837
May	1,382
June	872
July	<u>4,039</u>
TOTAL	8,542*

Source: Office of New Initiatives, Minnesota Department of Human Services.

* Represents net (i.e., excluding disenrollment) new enrollment on the first of each month relative to the prior month. Thus, the total enrolled at any point in time will be less. The total differs from the 8,067 reported in Table II-1 because that figure incorporates disenrollments, usually due to loss of eligibility.

The overall assignment rate (the percentage of beneficiaries who do not voluntarily elect an MHP and are therefore randomly assigned) is so far 28 percent. This rate is already higher than originally hoped for and is likely to increase significantly as the enrollment process is accelerated. As of July, the state is providing HPIC with longer client lists, and fewer attempts will be made to contact each client. The assignment rate is higher in Hennepin (about 30 percent) than in Dakota (about 24 percent). This may be because Dakota County Medicaid recipients tend to be less disadvantaged and better educated but also because all Medicaid beneficiaries are participating in Dakota County compared to 35 percent in Hennepin, which reduces the level

of confusion. The assignment rate is also higher for the AFDC population than for institutionalized populations, on whose behalf client advocates and staff of the facilities assist in the choice process. The assignment rate for nursing home residents has so far approached zero.

As expected, most clients pick MHPs for three main reasons:

- Existing provider relationships (appears to be the most important).
- Geographic accessibility.
- Hospital choices (a distant third).

D. DATA REPORTING

The state is interested in data on service delivery from several perspectives. First and foremost, data are critical to ensuring that the individual MHPs in fact deliver the services for which they are contracted; in particular, data are essential for identifying under utilization, a major concern in a capitated system. Second, comparisons among plans can serve to raise questions regarding the reasons for a particular plan differing from the norm in the services that are provided. Third, the data can potentially serve to help set capitation levels, particularly if the fee-for-service option is removed at a future date, thereby eliminating the usual benchmark for setting rates.

The primary approach that the state adopted is the requirement that each MHP provide dummy claims -- equivalent to itemized bills under fee-for-service reimbursement -- for all services rendered. These are to be submitted at the end of each quarter.

For some of the plans, the requirement is not viewed as burdensome. About half of them intend to transfer already computerized data, particularly those that have historically paid or billed fee-for-service. However, staff

model HMOs do not customarily collect such information, and doing so becomes a major burden. The problems Group Health has had in particular are addressed in the next chapter.

However, even those plans that already maintain records on individual services may not have complete information for Medicaid's purposes. For example, many HMOs do not record prescription numbers for pharmacy benefits or, for dental services, identify the number of the tooth. Whether the value of conforming the MHPs' systems to meet the standard Medicaid requirements is worth the cost still needs to be determined. In addition, the ultimate use of the data that the MHPs are required to submit has not been fully thought through.

E. COUNTY ROLE IN PROJECT MANAGEMENT

Hennepin and Dakota counties each have their own administrative offices for overseeing the demonstration. In both counties, the state reimburses all administrative expenses. For the first project year (October 1985 through September 1986), this amounted to \$250,000 in Hennepin and \$203,325 in Dakota. The structure and function of the county administrative staff differ somewhat between the two counties.

1. Hennepin County

In Hennepin County, the purpose of the Demonstration Project Office is to manage and evaluate the project at the county level; its focus is on assuring that clients continue to receive high quality care during the demonstration. However, some MHPs and other providers have expressed confusion as to the role of the Demonstration Project Office, as distinct from the state. County staff are: a Medicaid Demonstration Project Director, reporting to the county's Associate Administrator for Social Services, a planner, a statistical analyst, three accounting clerks, two financial workers (to be hired), and a secretary. The county's main responsibilities are evaluation (with an emphasis on mental health services), provider education, management of client grievances, and general troubleshooting.

County staff have a mandate from the commissioners to pay special attention to mental health services under the demonstration. Reflecting these priorities, a Mental Health/Mental Retardation/Chemical Health task force composed of representatives from the provider community (excluding MHPs) and from advocacy groups has been convened to study the provision of services in MHPs. The group has invited each of the MHPs to come present his or her plan's approach to providing services to these populations. One of the task force's early activities was to develop a system for monitoring the use of out-of-plan mental and chemical health services by demonstration enrollees. Mental and chemical health providers receiving county funds (the traditional mental health providers for the Medicaid population) have been asked to document services provided to demonstration enrollees. The county requests that they complete a form with information about why the client is seeking services, what types of services are needed, whether the provider expects to continue treating the client, and so on.

The county is currently managing three evaluation projects. The largest is a state-funded study contracted to the Center for Health Services Research at the University of Minnesota. The study will survey the noninstitutionalized aged and chronically mentally ill (800 of each) to determine how the demonstration is affecting health care access and quality. In addition, two small studies are being conducted by independent researchers; one focuses on nursing home residents and the other on the noninstitutionalized disabled.

Demonstration staff spend considerable amounts of time on provider education, both internally (e.g., county social and financial workers) and externally (e.g., community physicians, pharmacists, clinic administrators, and so on). Speeches and presentations are the major vehicle for communication, but the demonstration staff also prepare a quarterly newsletter to update interested parties on the demonstration's progress.

Hennepin County also manages the grievance process for its residents. When beneficiaries want to file a grievance, demonstration staff will solicit client and MHP views of the problem, convene a grievance panel, and follow-up on the panel's decision.

Finally, the county acts as a troubleshooter on behalf of both providers and beneficiaries, responding to individual questions as they arise. It also attempts to investigate problems as they are brought to the attention of the demonstration staff. For example, a few complaints about how Medicaid patients were treated by MHP staff over the telephone led the county to conduct some spot telephone checks to see whether clients were treated appropriately. No significant problems were found, other than occasionally long periods of time spent on hold.

2. Dakota County

In general, Dakota County has been more supportive and less skeptical of the demonstration than Hennepin County. The Dakota County project staff are more integrated into other county functions than in Hennepin County and, in part, because 100 percent of Dakota County Medicaid beneficiaries in the target groups are being enrolled, other county staff are well informed about the demonstration. The project director, who for the first six-months was the only full-time staff person working on the demonstration, is an individual with extensive experience in county government. Other Dakota County staff involved with the demonstration have other responsibilities but serve on a steering committee to guide the project. This contrasts with Hennepin County, where the demonstration office has less involvement with other county staff and the director was hired from outside county government or the Medicaid program.

Like Hennepin, Dakota County is particularly interested in mental health services. The county had originally planned to split out mental health services and capitate them separately from physical health services, principally to support a cadre of loyal, high quality providers currently serving the county's Medicaid clients. The county encouraged the provider agencies who were most active in caring for these populations to submit bids to be capitated for mental services only; they would be allowed to subcontract with other providers as needed. Despite the county's offer to share any losses with them on a fifty-fifty basis, the providers were afraid of the financial risk and did not submit bids.

As a result, the MHPs will provide mental health and chemical dependency services, but the county maintains its interest in the provision of these services. The county's human services planning staff worked with other county staff, local providers, and advocates to develop a program for analyzing the effects of the project on populations who use these services. This analysis has three parts:

- Client satisfaction survey for those who use mental health and chemical dependency services. The baseline data, from telephone and in-person interviews, will be collected by July 15, 1986. A follow-up survey of the same clients and using the same instruments will be completed in the summer of 1987.
- Monitoring requests for out-of-plan services. Using the Hennepin County form (see previous section) in order to enhance data comparability, the planning staff asked the county's largest mental health/chemical dependency providers and its public health nursing service to record all instances in which clients seek services which have not been approved by the MHP in which they are enrolled.
- Case history and anecdotal data. The planning staff will interview key informants, including advocates, providers, lawmakers, and others, for their opinions regarding the effects of the project.

The county is also active in provider education, informally fielding calls from many types of providers about the program. It will assume a new function in August 1986 -- client education and enrollment. The county has hired a second full-time staff member to handle enrollment and plans to bring on a third in August 1986. The broker now responsible for client education and enrollment will continue to perform its services for Hennepin County, as described in Section C of this chapter. Finally, as in Hennepin, Dakota County staff are the front lines for individual client problem-solving. The county deals with complaints but, unlike Hennepin, refers grievances to the state.

F. RAMIFICATIONS OF DEMONSTRATION ON OVERALL MEDICAID PROGRAM

The demonstration, even during its developmental stage, has had significant impact on the attitudes of the Medicaid staff generally and on the political and legislative process. However, it is too early to foretell its ultimate effects on the shape and dynamics of Medicaid.

The Deputy Commissioner of Human Services regards the demonstration as reflecting a radical change in the functioning of Medicaid by transforming the Department of Human Services that administers it from, on one hand, having a regulatory philosophy that at times focuses on the minutia of contract compliance to, on the other, becoming a purchaser of care with clearly articulated performance standards. In particular, the movement to prepayment shifts the emphasis and philosophy of day-to-day administration from a concern with controlling costs to assuring the adequacy of service delivery, a change that is affecting the whole Medicaid staff.

Related to this transformation is the need for the Department to acquire the new skills associated with purchasing care through capitation arrangements, a learning process that is still underway, as discussed further in the next chapter. In addition, the demonstration program has had difficulties obtaining adequate staffing levels. In the view of some observers, this reflects a longstanding reluctance on the part of the legislature to staff the Medicaid program generally. Currently, the program has a staff of eight, including clerical support. However, several of these individuals are assigned to the demonstration only part-time and/or are new to it and still learning about it. Furthermore, the legislature approves staff at fairly low organizational levels of the Department (the Department as a whole, or the Medicaid program within it, does not have a staffing ceiling within which they can operate flexibly), and the legislative process, often, cannot keep up with changing needs.

The demonstration has also had a profound effect on the politics of Medicaid. In 1985, the Governor proposed legislation to mandate statewide enrollment for the AFDC population in capitated plans, similar to the MHPs

that participate in the demonstration. This bill would not have been introduced were it not for the experience gained in developing the demonstration. At the same time, the existence of the demonstration has served as an argument for not mandating universal enrollment in such plans at this time, with opponents arguing that the demonstration should be allowed to run its course first and that the problems of slow startup indicate that the Department is not prepared to administer a statewide program.

In 1985, the proposal passed both houses of the legislature. However, technical differences between the two bills could not be resolved. One reason given was that a pharmacist, who served as a Representative in the House and who opposed the bill because of its potential adverse impact on pharmacists, argued that the MHPs should be required to contract with all providers. Many of the conferees did not understand the need to allow plans to select their provider networks and sufficient confusion ensued to prevent the bill's passage. In 1986, the bill failed to pass the House; whether it will be reintroduced next year and in what form is not yet known. However, the introduction and progress of the bill is indicative of the impact of the demonstration on the thinking of policymakers, many of whom view managed care systems as a means of controlling expenditures without reducing benefits. At the same time, the ability of the program staff to administer the program will affect the willingness of the legislature to extend the approach embodied in the demonstration.

CHAPTER FOUR

THE MHPs AND THEIR RESPONSES TO THE DEMONSTRATION

A. INTRODUCTION

As indicated in Chapter II, seven plans participate as MHPs in the demonstration. This chapter first offers an overview of the MHPs and then discusses their reactions to the demonstration to date.

B. OVERVIEW OF PLANS

Blue Cross and Blue Shield of Minnesota developed what it calls its "Sun Series" program specifically to serve the Medicaid population under the demonstration. Sun Series is an outgrowth of the Blue Cross and Blue Shield "Aware" PPO for commercial enrollees. Aware has entered into contracts with all of the acute general hospitals and with 98 percent of the fee-for-service physicians in the seven-county metropolitan area. Physicians who participate in Sun Series are a subset, amounting to some 70 percent, of Aware physicians. They agree to accept plan reimbursement as payment in full and to abide by its case management procedures. Reimbursement is at usual, customary, and reasonable (UCR) levels with a 20 percent withhold that is returned only if the overall program is within budget. Case management procedures include prior authorization for all nonemergency inpatient services plus selected ambulatory services. Enrollees have free access to specialists, but the plan profiles patterns of services delivered weekly to identify both over and under utilization (e.g., for prenatal care and childhood immunizations).

Interestingly, HMO Minnesota (HMOM), the Blues' HMO, did not respond to the state's RFP because the Blues did not want to use the primary care gatekeeper model of HMOM and because it has fewer participating physicians. Also, the Blues felt that using their HMO would give them less flexibility in program design.

The plan has contracted out certain functions:

- Health Cost Management Corporation in Minneapolis, a firm that specializes in managing workers' compensation cases, oversees the case management for the demonstration. It is devoting a full-time medical director and two nurses to the demonstration.
- Midwest Dental Association performs case management for dental care.
- ChiroCare is capitated for all chiropractic services.

Group Health, Inc., is the oldest HMO in the Twin Cities, dating back to 1957. It originally started as a staff model and employs 200 salaried physicians who practice out of 14 sites. It also contracts for the part-time services of 300 subspecialists. Enrollees select both a site and a primary care physician, who is responsible for referrals. However, self-referral is permitted for psychiatric and dermatology services. More recently, Group Health has networked with 19 fee-for-service group practices, which have a total of 100 primary care physicians. These groups are capitated for both physician and hospital services, with stop-loss arrangements. This networking has allowed the plan to expand its service area in recent years to 18 counties in Minnesota plus parts of western Wisconsin. The plan contracts with roughly two-thirds of the Twin Cities hospitals.

MedCenters Health Plan evolved from the Park Nicollet Clinic, the largest multispecialty group practice in the Twin Cities. The clinic delivers services at 21 locations. Each group is capitated for both hospital and physician services. The plan is now managed by American Medical Centers (to which plan staff of MedCenters was transferred), a publicly traded for-profit HMO management company in which the clinic has a major ownership. American Medical Centers now operates HMOs in Atlanta, Fargo (ND), Seattle, and Appleton and Madison, Wisconsin. One reason for the HMO company's participating in the demonstration is as a learning process that might be relevant for its ventures in other states.

Metropolitan Health Plan, operated by the Hennepin County Bureau of Health (HCMC), became licensed as an HMO in 1983 to serve the AFDC population. (The state's provision for voluntary AFDC enrollment in HMOs predated the demonstration project.) Metropolitan Health Plan employs a primary care clinic model, using the departments of family practice, internal medicine, obstetrics and gynecology, and pediatrics within HCMC as well as community clinics outside the medical center to deliver services. It has relations with four community clinics and is negotiating with three more. The clinics are staffed mostly with family practitioners, are publicly funded, and already serve the Medicaid population. Primary care physicians act as gatekeepers for specialty referrals, except for dentistry, eye care, mental health services including chemical dependency treatment, and chiropractic, where direct access is permitted. The plan is establishing a case management system that will employ a psychiatric nurse to handle mental health and chemical dependency cases, a geriatric nurse practitioner to work with the elderly, and a third professional to follow high risk acute care cases.

For the last two years, Metropolitan Health Plan has obtained a federal waiver allowing it to serve only Medicaid beneficiaries. However, this waiver will not be extended indefinitely and a major goal is to enroll commercial members, a task that will not be easy in the competitive, near-saturated Twin Cities market.

Physicians Health Plan (PHP) of Minnesota is an IPA model HMO that includes as its physician members some 90 percent of physicians in private practice. It is managed by Charter Medical Corporation, a wholly owned subsidiary of United HealthCare Corporation, which was created by the original management of PHP. United last year merged with SHARE Development Corporation, another HMO company headquartered in suburban Minneapolis. As of mid-1985, it owned or managed 26 plans in 18 states. With more than one million members nationwide, it is the largest HMO firm in the country.

PHP historically has achieved its savings through tough utilization review procedures. It has not adopted the primary care gatekeeper model and, instead, allows self-referral to specialists. There is a 20 percent withhold

on payments to physicians, the distribution of which is based on the performance of the plan overall. Thus the risk is collective and does not reflect the experience of the individual physician. PHP is concerned with its ability to break even under the demonstration, particularly as it (along with other HMOs in the demonstration) pays physicians at higher levels than does the standard Medicaid program. As a result, it is considering instituting stronger risk-sharing provisions on physicians for Medicaid patients than for private clients.

PreferredOne is a PPO that has been operational since 1984 and has roughly 12,000 members. It contracts with 12 hospitals and about 1,000 physicians. Physician payment schedules compare favorably with the BC/BS Sun Series and Physicians Health Plan. Commercial members have open access to all services, without a gatekeeper system. Medicaid members, however, have a separate identification card indicating that primary care physicians must authorize any referrals. At present, only dental, mental health/chemical dependency services, and emergency care do not require referral. Although physicians are case managers for most patients, PreferredOne is cautious about asking physicians to assume too much responsibility in this area because of the administrative burden. It thus hired a social worker to help with cases that will require more assistance, such as disabled members, and/or more oversight, such as abusers of the system who might overuse emergency services.

U-Care, which is not a licensed HMO, is an MHP operated by University Affiliated Family Physicians at the University of Minnesota. University Affiliated Family Physicians operates seven family practice clinics and also contracts with other HMOs. However, its primary activity is U-Care, which was formed in 1985 because the University did not want to lose its base of Medicaid patients.

U-Care's physicians include about a dozen family practice faculty members and approximately 100 residents. The primary care physician acts as the case manager but is supported by a team that includes nurses and a social worker where appropriate. There is direct access for dental and chiropractic services. All other referrals, including mental health, are through the

primary care physician. The plan uses five hospitals, including University Hospital. BC/BS acts as a fiscal intermediary for U-Care, which facilitates enrollment and billing and allows the plan to obtain BC/BS rates from hospitals. Three levels of care -- primary, secondary, and tertiary -- have been defined for reimbursement purposes. Clinics are capitated for a defined set of primary care services. The five participating hospitals are paid discounted charges through BC/BS for secondary services. Selected tertiary services are provided by University Hospital through a capitation contract that puts the hospital at risk for hospital and physician services.

C. PLAN RESPONSES

The reactions of the MHPs to the demonstration are discussed below under the headings of (1) the nature of the competition, (2) changes in services delivery, and (3) relations with the state.

1. Nature of Competition Among MHPs

Competition among the MHPs to date has been muted, for two reasons. The first relates to the nature of the Medicaid program and the constraints imposed on the MHPs. HMOs and other alternative delivery systems generally compete against each other for private enrollees on the basis of price and comprehensiveness of benefits. However, both forms of competition are largely precluded under the demonstration. The state establishes what it will pay the plans, which in turn are not allowed to charge premiums to enrollees. With regard to benefits, the list of services covered by Minnesota's standard Medicaid program is a long one, allowing little room for competition on benefits.

In practice, access is the major basis for competition, to the extent that competition occurs at all. As a result, the plans that offer the widest physician choice (PHP and BC/BS) gaining the greatest enrollment, mostly because many enrollees prefer to stay with their current physicians. This form of competition raises three issues: First, the sicker patients are the most likely to want to avoid changing physicians, possibly generating adverse selection against the plans with the broadest choice of physicians. (On the

other hand, both U-Care and Metropolitan Health Plan are concerned about adverse selection as well, because the Medicaid population has heavily used their primary hospitals, HCMC and University, for serious illness in the past.) Second, some plans believe that staff employed by the broker favor the MHPs with the broadest physician selection, believing that the beneficiary is often best served by not having to switch. Whether this represents a bias on their part because they do not fully understand prepayment or, instead, is a reasonable approach to helping beneficiaries is a matter of debate. Third, the physician who participates in more than one MHP may influence the selection process and, therefore, recommendations may be affected by differences in how he or she is paid rather than by patient needs alone.

The second reason for limited competition is that the demonstration is new and is not viewed by the MHPs as financially remunerative. Some of the HMOs report negative financial experiences under the voluntary AFDC HMO program and none of the large, commercially oriented plans regard the demonstration as a major money maker. Two HMO representatives indicated that their participation was strongly influenced by a sense of social obligation and said that they were not seeking a large Medicaid enrollment. One representative commented that "most of us have limited experience with this population and are being cautious the first year." Both the long-term financial effects and whether the sense of caution and not wanting to compete actively will continue are matters of conjecture at this time. In contrast, plans that rely on the Medicaid population as their major source of business, i.e., Metropolitan Health Plan and U-Care, view a successful experience under the demonstration as critical to their long-term viability.

2. Service Delivery

None of the plans indicated that they were reorienting the services that they have traditionally provided (e.g., physician and hospital) to meet any unique needs of the Medicaid population. They were not, for example, making special efforts in the areas of prevention or maternal and child health.

The HMOs have, however, had to provide or arrange for new services, because Medicaid is more comprehensive than most private insurance. New

services (not all of which are new to every plan) include: optometry, hearing aids, medically necessary transportation, disposable medical supplies (e.g., bandages), over-the-counter drugs, contraceptives, and podiatry services.

Also somewhat ambiguous is the scope of mental health services which, as described in Chapter V, has been a major source of contention. The state's guidelines only specify that medically necessary services need to be provided. Whether, for example, that includes services through psychiatric social workers is an open question. Some of the plans have handled mental health services, most notably for the chronically mentally ill, by contracting with community mental health centers that now serve the Medicaid population, in part because they believe themselves to be under a microscope for these services because of the controversies surrounding them. Doing so takes the plans "off the hook" by contracting with traditional providers.

3. Relations with State Medicaid Program

One MHP representative said that the relationship between the MHPs and the state represented "the blind leading the blind; both the state and we are learning and making adjustments." The overall perspective of the plans is that many of the problems that have resulted could have been anticipated.

One common complaint is the lack of clear policy directives. In some instances policy decisions were described as ad hoc and too often communicated orally rather than in writing. Examples of areas requiring resolution are:

- how to interface with the state's preadmission review procedures for nursing homes;
- the circumstances under which occupational therapy should be covered;
- the extent of plan responsibility to pay for care in residential treatment centers; and

- who has responsibility for the case management of the chronically mentally ill and the mentally retarded, traditionally a county function.

A major problem has been the slow start-up of the program, which has resulted in the plans having to spread fixed costs over a smaller number of enrollees than had been anticipated. There have also been day-to-day problems of administration. Maintaining enrollment data current has been a significant problem, as it often is in state programs of this nature. However, it is compounded by the involvement of the county and the broker in addition to the state. MHPs are sometimes informed of new enrollees after the beginning of the month in which eligibility begins rather than at the end of the month before. Another problem is retroactive deletions, resulting in the plans providing care for which they are not compensated. The plans feel that the state has too broad an authority to retroactively reclaim capitation payments at any time.

Also, at the time we conducted our interviews, the state was not providing information on third party liability, i.e., the presence of private insurance with which the MHP can coordinate benefits. The rate setting methodology assumes that the MHPs will recover payments from private third parties in a manner similar to the regular Medicaid program. However, the state retains the responsibility for identifying patients with other coverage. This problem has since been corrected.

Coding errors are another problem, e.g., plan choice being incorrectly coded. Again, the reliance on the county, over which the state in practice has limited control, is viewed as a contributing factor.

Another administrative problem cited is the lack of education of both the nursing homes and the MHPs regarding how to administer the nursing home benefit. One policy decision made earlier on was that persons in nursing homes at the time they entered the demonstration would not have to shift to another institution. The effect is to require that every MHP deal with virtually every nursing home. Interestingly, none of the plans were troubled

by the requirement; some said that they were already dealing with many of the nursing homes. However, the nature of the relationship is a new one from their perspective. Furthermore, the administrative systems of the nursing homes were being disrupted to handle a minority of their patients.

The issue of dummy claims forms has been a major one with some of the plans, particularly those that are not accustomed to fee-for-service billing. In order to assess access and quality as well as to determine when the state-funded stop-loss provisions were triggered, the plans are required to submit dummy claims forms, which are the equivalent of fee-for-service bills. Many of the plans already have systems to collect this information, although not necessarily in the same format (for example, the state requires that for dental work the number of the tooth be recorded on the bill, something that plans may not do routinely). These plans can readily meet the requirement by simply transferring existing computerized data. The requirement has been problematic, however, for three plans which must prepare the dummy claims manually. Group Health, a staff model HMO, now extracts medical records manually requiring one full-time employee for every 800 medical records. The other two plans, PreferredOne and Metropolitan Health Plan, report that so far the burden has been light, but that as enrollments grow, this will change. Concern was also expressed with how the state would use this information, given its orientation to search for over rather than under utilization. In response, the state argues that its data base and programs are flexible and can serve to spot under utilization.

No one appears to fault the demonstration staff for its competence or diligence, although there is some feeling that certain aspects of program administration should have been accorded a higher priority before the program was implemented. Insufficient staffing has been a factor, and perhaps the plans themselves should have assumed greater responsibility for anticipating problems. On the other hand, the plans would argue that the state should have solicited their help in anticipating the types of problems that would arise.

Finally, the MHPs feel that politics have affected the demonstration negatively in some ways. First, joint state/county administration in a climate of uneven intergovernmental relations leads to administrative problems

and inefficiencies. Second, the Medicaid population is "everybody's constituency," according to one plan. The emphasis has been on making sure that nothing happens to enrollees and that special populations are treated appropriately. While the MHPs do not object to such concerns, they felt in some instances HMOs were found guilty before any changes had been brought and that MHPs were unnecessarily and unfairly put on the defensive from the start, particularly over mental health issues, where there were widespread allegations that HMOs under-provide necessary mental health services.

However, the general perception is that the important issues are beginning to be addressed. One recently created vehicle for so doing is monthly meetings among the plans as well as monthly meetings with the state. These meetings are viewed as helpful in improving communications and achieving resolution of problems.

CHAPTER FIVE

CONSUMER AND PROVIDER REACTIONS

In Minnesota, the concept of capitated payments for health services is generally well accepted, so that much of the discussion about the project with these groups relates to details of policy and implementation, not philosophy. Most consumer and provider groups participated in planning for the demonstration and have adopted a "wait and see" attitude toward it until enrollment levels increase and more experience is gained. All interviewees, however, felt it was important to assess the results of the demonstration more fully before implementing the program statewide.

A. CONSUMER PERSPECTIVE

Most of the reservations expressed by advocacy groups and other representatives of Medicaid recipients are based on anticipated rather than actual problems, because there are still only small numbers enrolled. Many of these surfaced in the planning stages and are being held in abeyance until the populations perceived as particularly vulnerable have had more experience receiving care from MHPs. The population about whom the greatest reservations have been raised, i.e., the noninstitutionalized disabled (including the mentally retarded and the chronically mentally ill), has not yet been enrolled. This group will begin enrollment in late summer or early fall of 1986.

Overall, the greatest concerns have been expressed about the provision of mental health services. Apart from the demonstration, there has been considerable negative publicity in the Twin Cities media in the last year or two about problems of access and lack of specialized mental health providers in HMOs. Community mental health providers believe that HMOs do an inadequate job of delivering mental health services to their membership in general, and that they are ill-equipped and unmotivated to provide the special services needed by some of the subpopulations included in the demonstration. Because of the sensitivity surrounding mental health, these issues became a focal

point of the political debate between the county and the state. Under the demonstration, mental health and chemical health advocates question whether Medicaid clients will have adequate access to services. They particularly question whether efforts by MHPs to reduce utilization may lead to reductions in service that are not in the client's best interest.

In addition, there is concern about other vulnerable subpopulations participating in the demonstration. The only group with actual experience to report to date is the Nursing Home Residents Advocates. Social workers representing nursing home residents have had trouble getting responses to pre-authorization requests from two MHPs. In one case, several hours elapsed before an urgent psychiatric admission was approved. In other cases, treatment has been delayed when MHPs did not return calls requesting authorization. Second, some MHPs have reportedly discouraged physical therapy, and nursing home staff are under the impression that fewer orders for physical therapy are being written. However, whether the lower use of physical therapy represents under service or a warranted economy is not known.

Some of the other potential problems raised by various client advocacy groups and consumer representatives include the following:

- Most MHP providers have had little experience with the mentally retarded. Providers who are not knowledgeable about the mentally retarded, or who lack the expertise and/or willingness to deal with them, may not take the extra time needed to explain issues to patients, leading to confusion, fear, and noncompliance.
- Access to care for the chronically mentally ill (those with schizophrenia, manic depression, personality disorders, etc.) is another possible problem. It is important for these patients to have easy access to medical care because of the need for chronic medication; they are often not motivated to stay on medication, and if access to the physician or the drugstore is inconvenient, the risk of noncompliance is greater.

- Many MHPs have limited experience treating the physically disabled. Providers unaccustomed to treating the handicapped may lack the attitudinal awareness and sensitivity needed to work with this population.

Finally, many of these populations routinely see multiple providers. Thus, it may be almost impossible for beneficiaries to maintain existing physician relations when they select an MHP.

The state is aware of these problems and has attempted to educate providers participating in the demonstration. For example, it has held three training sessions on the needs of special populations. Sessions were held on the mentally retarded, the chronically ill and/or physically disabled, and the chronically mentally ill.

B. PROVIDER GROUPS

Perspectives on the demonstration project vary by provider groups but on the whole range from neutral to mildly enthusiastic in the hospital and nursing home industries as well as among physicians.

1. Physicians

Overall, physicians are supportive of the demonstration. Virtually all practicing physicians in the Twin Cities participate in one or more prepaid health plans, and the inevitability of prepayment is accepted. In addition, of all the provider groups, physicians may have the most to gain from the demonstration because the project has potential for allowing them to receive higher rates of reimbursement for Medicaid recipients than under the straight fee-for-service program. Medicaid currently pays under fee-for-service at the 50th percentile of 1982 usual, customary and reasonable (UCR) charges. This amounts to a reduction of more than 40 percent on average from full billed charges in 1986. While HMOs do not necessarily recognize full billed charges, they tend to pay physicians more than the Medicaid program. In addition,

under the demonstration project, physicians submit claims to the MHPs rather than to the state, and the MHPs are viewed as easier to deal with and less arbitrary.

As a group, the major issues raised by physicians in the planning stages of the demonstration were access and continuity. The two tenets stressed were:

- Any physician who wants to participate should be able to.
- Medicaid patients with existing physician relationships should be able to maintain them.

The fact that seven MHPs are offered, including the BC/BS Sun Series plan and PHP (with broad physician panels), successfully defused these concerns early on.

Additional issues raised by representatives of physician groups include the following:

- Access to psychiatric care could be unduly restricted, since health plans tend to triage patients and restrict access to psychiatrists.
- The random assignment process does not include any consideration of where beneficiaries live, which could inconvenience clients and cost the state more money (because the county and federal government pay for transportation costs).
- The lack of a central source of information on eligibility means that providers may have difficulty determining what health plan a client belongs to. This could result in a physician treating a patient and being denied payment by the MHP.

2. Hospitals

Twin Cities hospitals followed the demonstration's early progress but have been much less actively monitoring the project lately. The demonstration

does not appear to raise any major new issues for hospitals, nor does it materially affect their existing relationships with HMOs and the other health plans. Significant shifts in Medicaid patient volume have not yet been felt. Like physicians, however, hospitals need to be aware that nonemergency services provided to Medicaid clients who are part of the demonstration may result in a denial of payment by the MHP if the services were unauthorized.

3. Nursing Homes

The nursing home industry is neutral about the demonstration. It has been preoccupied with issues other than the demonstration, in particular the new case-mix payment system which sets rates for nursing home care under Medicaid. Other issues have taken a back seat.

There are two nursing home associations in Minnesota: one represents nonprofit homes, which account for a majority of beds in the state, and the other represents for-profits. Both associations agree that there really is not a demonstration project for nursing home care. This is because room and board costs are passed through the Medicaid case-mix system,* even though other services, such as ancillaries, can be negotiated between the HMO and the nursing home. Above all, the associations had hoped the demonstration would involve an exemption from the standard Medicaid payment system, allowing nursing homes to provide different services at different rates, and they are disappointed that such flexibility was not incorporated into the project.

However, the associations feel that this preservation of the status quo and protection of the homes from competition in the demonstration is a mixed blessing. Some homes, particularly the for-profits, are more eager for the chance to assume some risk, and potentially benefit as well. This is in part because their occupancy rates are running a few percentage points lower than in the past. The nonprofits, on the other hand, have higher occupancy rates on average and are less interested in bearing risk.

* The pass-through only occurs after the first 90 days of care for patients newly entering a nursing home. It also applies to beneficiaries residing in a nursing home at the time they enroll in an MHP.

Another concern is the need for nursing homes to interact with as many as seven different MHPs, each of which could require the home to deal with different ancillary providers and comply with different administrative systems. However, it is still too early to determine the severity of this problem.

CHAPTER SIX

THE DEMONSTRATION IN ITASCA COUNTY

A. INTRODUCTION

Our April 1984 report focused exclusively on the demonstration in the Twin Cities. Although smaller in scope, the demonstration in Itasca County represents an innovative approach that might be emulated by other similarly situated counties, particularly those in rural areas. In a nutshell, the county itself is capitated as an MHP for all Medicaid beneficiaries, other than the excluded groups described in Chapter II. Although legally the county is at risk, in practice it transfers most of the risk to participating providers.

This chapter presents an overview of the demonstration in Itasca, based primarily on a lengthy interview and subsequent follow-up conversations with the person primarily responsible for implementing the demonstration for the county government. A member of the Lewin and Associates project team will perform a site visit to Itasca later this year and report on the demonstration there in greater detail. The chapter first describes the origins of the demonstration in Itasca County. It then discusses the provider structure and the reimbursement mechanism. Finally, the administration of the program and some of the associated issues are summarized.

B. PROGRAM ORIGINS

Itasca is a rural county in northern Minnesota. It has a population of 44,000, some 8,000 of whom live in the town of Grand Rapids. It is heavily dependent on mining and in recent years has suffered from retrenchment in the mining industry. As a result, the economy is depressed and unemployment exceeds 15 percent.

Starting in March 1983, the county initiated a program with the state under which the county was capitated for services to the General Assistance

populations.* The demonstration represents an extension of that approach to the Medicaid populations. The Medicaid demonstration started on July 1, 1984, with the enrollment of the Aged, Blind, and Disabled and on August 1, 1985, for the AFDC population. Currently, some 3,700 are enrolled.

Both the General Assistance program and the Medicaid demonstration were generated by physicians locally, for two reasons. First, the physicians viewed a capitation program as a way to obtain higher levels of reimbursement by allowing them to reap the benefits of the efficient utilization of services, such as through lower inpatient use, the avoidance of duplicate testing where a referral is involved, and better controls on referrals. Second, some 20 percent of services rendered to Medicaid beneficiaries who reside in the county are delivered elsewhere, mostly in Duluth, the Twin Cities, and Rochester (home of the Mayo Clinic). The demonstration becomes a vehicle for reducing the amount of care received outside of the county, which contributes to the revenues of providers as well as to the county's economic base.

The county benefits financially in two ways. First, counties in Minnesota are responsible for 10 percent of the state's share of benefit payments. Under the demonstration, that amount is reduced by half, and the county's liability is only 5 percent. Second, the economic discipline that the demonstration introduces for Medicaid is also expected to influence the cost of care in the county generally.

C. PROVIDER STRUCTURE AND REIMBURSEMENT

The county has roughly 40 physicians and three hospitals. Most physicians practice in groups; there is one multispecialty group practice and

* The General Assistance program covers populations, mostly single persons and couples without children, who are not eligible for federal Medicaid matching funds regardless of how low their income, because they are not "categorically related." It is funded entirely by state and local governments.

four single specialty group practices. The demonstration operates like a primary care network IPA type of HMO, meaning that enrollees are required to elect a primary care physician, and all services must be rendered by or upon referral from that physician.

The major hospital, Itasca Memorial with 143 licensed beds, is owned by the county and serves populations of all income levels. There are two other hospitals in the county, both with fewer than 50 beds: (1) North Itasca, a district hospital in Big Fork that serves the northern part of the county and (2) Community Memorial, a nonprofit facility in Deer River.

Mental health services are delivered exclusively through the Northland Mental Health Center, a private nonprofit community mental health center that contracts with a range of providers.

Chiropractic services under the demonstration are delivered through ChiroCare of Minnesota, which has seven chiropractors and receives 50 cents per enrollee per month as a capitation payment. The remaining amount available to pay for patient care is divided into four risk pools as follows:

Institutional	49.5%
Medical (mostly physician services)	31.0
Mental Health	7.5
Dental	<u>12.0</u>
Total	100.0%

During the year, institutional providers (primarily the county hospital) are paid full billed charges less 10 percent. Physicians, dentists, and other noninstitutional providers within the county are paid fee-for-service based on usual, customary, and reasonable (UCR) charges (i.e., full billed charges in most instances), less 10 percent.

After the year is over, any surpluses or losses are distributed in the following manner: first, deficits in any individual risk pool are offset from surpluses, if any, in one of the other pools. After that, for each of the pools, surpluses are distributed to participating providers in proportion to

their billings under the program, with the exception of surpluses in the institutional pool, which are shared fifty-fifty with participating physicians.* If there are deficits beyond the 10 percent discount, the providers are legally required to pay back losses out of future revenues, and participating providers are to be billed should future revenues not be sufficient.

D. PROGRAM ADMINISTRATION

The county administers the eligibility process, as do counties throughout Minnesota. Ongoing program administration has been contracted to HMO Minnesota (HMOM), the HMO established by Blue Cross and Blue Shield of Minnesota, which receives \$5 per enrollee monthly out of the capitation payment. That contract was not competitively bid, and HMOM was selected largely because many of the doctors locally participated in the plan already and were comfortable with it. The functions of HMOM include processing claims, handling provider relations, and performing utilization review, including preadmission and concurrent review. It also profiles physician practice patterns by diagnosis.

The county reports that implementation has proceeded smoothly overall. The major problem with beneficiaries was getting them to select primary care physicians and not to self-refer to specialists. Problems have also been encountered with computer systems, notably with the issuance of eligibility cards and, on the part of the state, making the capitation payment to the county.

* The proportion of surplus due to hospitalization on a psychiatric unit is shared with the Northland Mental Health Center.

CHAPTER SEVEN

ISSUES

Our April 1984 case study concluded with a discussion of some of the issue that have arisen in the Minnesota demonstration, many of which have relevance to other states, specifically:

- The nature of the state's decision-making process, particularly the extensive involvement of an elaborate outside advisory committee structure.
- The nature of competition among plans.
- The effect of individual physicians being affiliated with more than one plan.
- The role of the county.
- Problems of rate setting.
- Problems in dealing with the nursing home population.
- The impact of the demonstration on groups of enrollees with particular problems, e.g., the mentally ill, the mentally retarded, and the physically handicapped.
- The impact on the near-poor.

We will continue to follow these issues and have reported on most of them in this case study. In our final case study, to be completed in 1988, their evolution over the full five-year course of the demonstration will be discussed. To the above list, we would also add the following issues that have arisen during the first months of implementation:

- Minimizing administrative problems during the start-up period. A number of start-up problems have occurred due to policies that are unclear and to data flow and management issues that are incompletely addressed. Some of these problems were inevitable. However, one set of lessons from the demonstration relates to how other states wishing to adopt similar programs might create a process or take steps to minimize such problems.
- Streamlining the enrollment process. There is a tension between expedient enrollment of Medicaid recipients and the consumer education process. The efficiency of enrollment declines as clients are allowed additional time to elect an MHP and are provided with extensive opportunities for learning about the demonstration. A more accelerated enrollment schedule, on the other hand, results in less opportunity for consumer choice and a higher rate of assignment to MHPs which may, in turn, result in more confusion and higher out-of-plan use.
- Monitoring MHP performance. State representatives, advocacy groups, and others have expressed the need to monitor the MHPs to assure that beneficiary access and service delivery are adequate. Yet an approach that produces relevant performance indicators and does so in a manner that is not overly intrusive for the plan has yet to be devised.
- The future of the MHPs beyond the demonstration. As part of the demonstration, HCFA waived several of the federal Medicaid provisions for prepaid health plan contracting, such as the requirement that 25 percent of enrollees be other than Medicare or Medicaid beneficiaries. How the plans will adapt, or indeed whether some can continue beyond the period of the demonstration, is an open question. A related issue is whether some of the smaller MHPs with only Medicaid enrollees will remain financially solvent so that they can bear the risk for this population on an ongoing basis.

- The limits of capitation under Medicaid. The state has attempted to capitate as much of the Medicaid program under the demonstration as possible. The most noteworthy innovations relative to other states are the inclusion of the Aged, Blind, and Disabled populations. Yet more than two-thirds of Medicaid expenditures are still not capitated, because certain services (mostly nursing home) and population groups are still reimbursed fee-for-service. This raises the question of how far prepayment can be extended under Medicaid or, alternatively, how large the residual fee-for-service program must be.

LIST OF INTERVIEWEES

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Nursing Home Residents Advocates

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Mr. John Oswald
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Evaluation of Medicaid Competition Demonstrations

Volume VI

The Missouri Managed Health Care Project

by

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Lewin and Associates, Inc.

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PREFACE

In September 1983, the Office of Research and Demonstrations in the Health Care Financing Administration awarded a contract to a consortium, headed by the Research Triangle Institute, to evaluate Medicaid competition demonstrations in six states: California, Florida, Minnesota, Missouri, New Jersey, and New York. An important aspect of the evaluation is the preparation of case studies in each of the participating states. These case studies are the responsibility of Lewin and Associates, Inc., and the American Enterprise Institute. Four case studies for each state demonstration will be issued annually or at another reasonable time interval.

This report presents the second case study for the state of Missouri. It reports on activities during the first year of operations. The first case study, published in April 1984, covered the history of and planning for the demonstration. Material from the first report is not repeated here, except in summary form. Key findings from the first case study are summarized in Chapter One.

The author wishes to thank the many people in Missouri who made this second case study possible. I especially want to acknowledge the cooperation and contributions of state officials, particularly staff of the Prepaid Health Unit; physicians; and representatives of the hospitals, neighborhood health centers, and prepaid plans participating in the Missouri Managed Health Care Project (MHCP). In addition, I am grateful for the candor of several representatives of health care provider associations and consumer groups who were interviewed for this case study.

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CHAPTER ONE

INTRODUCTION

Since November 1983, Medicaid recipients in Jackson County, Missouri, have been enrolled in a Managed Health Care Project (MHCP). Recipients are given the choice of selecting either a prepaid health plan (PHP) or a primary care physician participating in the Physician Sponsor Program (PSP). PHPs are similar to health maintenance organizations (HMOs) because they assume financial risk for the provision of comprehensive health services. In contrast, primary care physicians in the PSP are not financially at risk; they are paid a monthly fee for managing the care of enrolled recipients in addition to fee-for-service Medicaid reimbursement for services they provide directly.

The first report on the Missouri MHCP was published in April 1984, five months after the demonstration became operational. That report focused primarily on the history, planning, and early operations of the demonstration. Specific findings included the following:

- In 1982, to avert a projected Medicaid budget deficit of \$87 million, the state adopted over 170 short-term cost saving provisions and decided to develop prepaid health plans as a long-term reform.
- After adopting drastic Medicaid cuts, the Missouri state legislature was eager to try a more systematic approach to Medicaid reform. The prepaid health plan legislation was enacted with little opposition.
- However, certain interest groups successfully modified the prepaid health plan demonstration. Physician groups ensured that Medicaid patients would continue to have the option of choosing private, fee-for-service physicians. This was the genesis of the PSP. In addition, pharmacists succeeded in excluding outpatient prescriptions from prepayment.

- In the Spring of 1982, once a federal grant was secured, the Missouri Department of Social Services formed a Prepaid Health Unit to plan and implement the MHCP. Planning for the demonstration took 17 months. While the original timetable called for enrollment to begin in March 1983, the first group of patients was not enrolled until November 21, 1983. The delay was due to lengthy provider negotiations and difficulties implementing new management information systems and claims processing procedures.
- The state selected Jackson County, which includes Kansas City and Independence, as the first site of the MHCP.
- In Jackson County, a variety of organizations participate in the demonstration as PHPs, including an established health maintenance organization (HMO), two hospitals, and two neighborhood health centers. Four of the PHPs had no prior experience with prepayment. They were uncertain about the organizational changes necessary to manage risk. In addition, the established HMO had never before treated Medicaid patients and was unaccustomed to Medicaid regulations and reporting requirements.
- Negotiations with physician sponsors were lengthy and controversial. The state's project team met with Jackson County primary care physicians and specialty organizations to solicit their support and cooperation. As of March 1984, 50 primary care physicians had contracted to be physician sponsors.
- At the time the first case study was published, almost 4,000 out of a potential 30,000 Jackson County Medicaid recipients were enrolled in the MHCP. These recipients selected either a PHP or physician sponsor following a presentation by trained Medicaid Choice Workers in the county Department of Social Services office. Enrollment patterns revealed that they were choosing their usual providers of care.
- In the first phase of the demonstration, prepaid plans and physician sponsors were still adjusting to the new incentives and procedures. Changes in practice patterns had not yet occurred, and neither plans nor sponsors had begun to compete for patients.

This is the second report on the Missouri MHCP. It covers developments in the MHCP as of March 1985, a year and a quarter after the program began serving patients. The first year of operations was marked by adjustments -- by both providers and enrollees -- to new incentives and

procedures. In response to problems and unforeseen administrative issues which arose during the first year, the Missouri Department of Social Services has modified some aspects of the program. It has also instituted new procedures for financial reporting and quality assurance. Statistics on expenditures and utilization began to be collected toward the end of the 1984 and are not yet complete. As a result, we cannot report on the financial performance of participating PHPs and physician sponsors.

This report is based primarily on interviews conducted during a visit to Missouri in the last week of March 1985. Two days of interviews were held with state Medicaid officials in the Department of Social Services and representatives of state provider organizations in Jefferson City, the state capital. Three additional days were spent in Jackson County interviewing staff of participating health plans, participating physicians, and consumer groups (a list of persons interviewed is presented in Appendix A).

This case study has five additional chapters:

- Chapter II: Overview of the Demonstration and Environment, which describes the demonstration and places it into context by describing competitive pressures affecting health care providers in Jackson County and reviewing recent policy changes in the Missouri Medicaid program.
- Chapter III: State Implementation and Oversight, which chronicles state management activities.
- Chapter IV: PHP and PSP Activities, which reports start-up activities and performance of participating health plans and physician sponsors and describes the difficulties encountered during implementation.
- Chapter V: Consumer Perspective, which describes consumer behavior and reports the reaction of consumer groups to the demonstration.
- Chapter VI: Conclusions, which describes issues that have arisen during the first year of operations and presents findings that may be of particular interest to other states.

CHAPTER TWO

OVERVIEW OF THE DEMONSTRATION AND THE ENVIRONMENT

A. INTRODUCTION

As part of a long-range plan to improve access to medical care and to control seemingly relentless increases in Medicaid expenditures, the State of Missouri hopes eventually to extend the prepaid health plans and physician sponsor program to other areas of the state. Jackson County was selected as the initial test site. This chapter provides an overview of the Jackson County MHCP and describes the competitive environment in which it operates. In addition, recent Medicaid changes which could affect the demonstration are reviewed.

B. OVERVIEW OF THE MHCP

Jackson County, which includes Kansas City and Independence, was chosen as the first MHCP site because its Medicaid population is of moderate size, and the provider community is stable and cooperative. In 1980, the Kansas City metropolitan area population was 1,327,106 and the population of Jackson County was 629,180. Medicaid expenditures in Jackson County were \$53* million in FY 1984, or about 12 percent of total state Medicaid expenditures of \$433 million.**

* This figure includes General Relief.

** This figure excludes certain categories of Medicaid expenditures, including those for state institutions.

Currently, MHCP enrollment is limited to approximately 27,000 recipients of Aid to Families with Dependent Children (AFDC). (Eventually, enrollment may be expanded to other Medicaid eligibles.) AFDC recipients account for approximately \$16.7 million, or 31.5 percent of total Medicaid expenses in Jackson County.

The Jackson County MHCP offers AFDC recipients a choice between PHPs and physician sponsors.

1. Prepaid Health Plans (PHPs)

Five organizations have agreed to participate as PHPs:

- Two Hospitals: Truman Medical Center and University of Health Sciences.
- Two Neighborhood Health Centers: Wayne Miner Health Center and Swope Parkway Comprehensive and Mental Health Center.
- One HMO: Prevention Plus, an independent practice association (IPA) sponsored by Blue Cross and Blue Shield of Kansas City.*

Table II.1 shows the enrollment for each PHP as of August 1, 1985.

* A second HMO, known as Prime Health, had originally intended to participate, but eventually withdrew. Their primary concern was that they had negotiated rates with hospitals which were above Medicaid rates and could not be renegotiated. The state did not actively pursue the plan because the total eligible population was not large enough to warrant participation of a sixth plan.

TABLE II.1
ENROLLMENT IN THE MISSOURI MANAGED
HEALTH CARE PROJECT

August 1985

	<u>Enrollment</u>	<u>Percent</u>
Truman Medical Center	7,835	34.2%
University of Health Sciences	2,424	10.6%
Wayne Miner Health Center	1,884	8.2%
Swope Parkway Comprehensive and Mental Health Center	2,943	12.8%
Prevention Plus	4,228	18.5%
Physician Sponsor Program	<u>3,593</u>	<u>15.7%</u>
TOTAL	22,907	100.0%

Source: Missouri Department of Social Services.

The PHPs are required to offer a comprehensive benefit package composed of virtually all of the benefits offered through the Missouri Medicaid program. However, pharmacy, dental, personal care, adult day health care, emergency transportation, and nursing home care are excluded from PHP benefits and are covered on a fee-for-service basis. Plans may also elect to offer additional benefits beyond the basic Medicaid package. If they elect to provide dental and emergency transportation, they may receive a separate capitation amount. The capitation rate for dental is \$5.31 per month for adults and \$2.40 per month for children. For ambulance services, the state pays an additional \$0.21 per month for both adults and children. At present, none of the PHPs offer these additional benefits.

As an incentive to select a PHP, the state decided that clients will not be required to pay copayments for any services provided by a PHP. In addition, certain Medicaid program requirements are waived for PHPs. For example, Medicaid service limits (e.g., number of emergency room visits per recipient) and provider controls (e.g., second opinion on elective surgery), are eliminated. Finally, the first time they enroll, recipients who select a PHP are guaranteed six months eligibility from the time their eligibility becomes effective.

PHPs are reimbursed a monthly capitation amount set at approximately 90 percent of what the state would have paid ordinarily for each recipient's health care. In FY 1985, the rate for an AFDC case head was \$92.61 and the rate for a child (dependent) was \$43.71. Ninety percent of this cost is: \$83.35 and \$39.34, respectively. The PHPs may offset part of their risk through state-arranged reinsurance pools. The state automatically deducts a portion of the base capitation rate in exchange for this protection. Three mandatory risk-limiting provisions have been established: (1) fee-for-service Medicaid reimbursement for maternity and newborn hospital stays in excess of 9 days, (2) a reinsurance pool for an excessively high number of deliveries per

year, and (3) a fund for adverse selection. In addition, the state has established an optional risk limitation which involves an additional deduction from the base rate each month. It is a catastrophic stop-loss arrangement whereby Medicaid claims exceeding \$20,000 for an enrollment year are reimbursed from a pool. Selection of another optional risk provision permits the plans to collect and retain payments from any third party insurance the AFDC recipient may have.*

2. The Physician Sponsor Program (PSP)

As of August 1985, 54 primary care physicians in Kansas City had agreed to participate and 15.7 percent of AFDC recipients had selected the PSP (Table II.1). As "primary care gatekeepers," these physicians provide basic medical care to enrollees, make all referrals to specialists, and manage all hospitalizations. In return, they receive a case management fee of \$1.50 per enrolled member per month in addition to normal Medicaid fee-for-service reimbursement for the services they provide. Unlike the PHPs, physician sponsors do not assume any financial risk.

Physician sponsors are required to complete a form for all referrals to specialists and to hospitals. Claims from referral providers and hospitals must be accompanied by a referral form signed by the physician sponsor.

C. THE COMPETITIVE HEALTH CARE ENVIRONMENT

Jackson County, Missouri, is a ripe area for health care competition primarily because the county has an excess supply of health care resources. In 1980, the physician-to-population ratio was 253 per 100,000 (compared to a

* For greater detail on risk pools, refer to Chapter Three, Section G.

national ratio of 204 per 100,000 population). Further, its hospital bed-to-population ratio was 742 per 100,000, compared to a national average of 490.*

Partly a result of these characteristics, the Jackson County health care marketplace has become highly competitive. In the last two years, a number of competing alternative delivery systems, such as HMOs and selective contracting arrangements, have sprung up in Jackson County. This competitive activity could have profound effects on the MHCP.

HMO growth in Jackson County and neighboring Johnson and Wyandotte counties (directly across the river in Kansas), has been particularly rapid. Whereas two and a half years ago, there were only two HMOs, there are currently five operational plans in the metropolitan area, including three IPAs and two staff model HMOs (Table II.2). In addition, at least two more HMOs (sponsored by CIGNA and Prudential) are rumored to be in the planning stages. As of April 1985, enrollment in the five operational HMOs had exceeded 187,000, more than a tripling in less than three years. HMO enrollments now represent 13 percent of the total population in the Kansas City metropolitan statistical area. The HMO market penetration in Kansas City is more than three times that of the St. Louis metropolitan statistical area (4.3 percent) and twice the national average (6.5 percent).**

At least five provider and insurer-sponsored preferred provider organizations (PPOs) have also begun to market in the Kansas City area. The largest PPO in the area is sponsored by Blue Cross and Blue Shield of Kansas City. Two of the PPOs are sponsored by hospitals that have formed networks and the last is a physician-sponsored PPO. Because the competitive environment is intensifying, sources report that at least three other PPOs are also believed to be forming in the metropolitan area.

* American Medical Association, 1982, Kansas City Osteopathic Association, and Missouri Department of Social Services, 1984.

** Missouri Governor's Task Force on Health Care Costs, December 1984.

TABLE II.2

HMOs IN THE KANSAS CITY METROPOLITAN AREA

<u>Plan</u>	<u>Model</u>	<u>Age</u>	<u>Enrollment (Spring 1985)</u>
Prime Health	Staff	8	55,000
Total Health Care	IPA	3	80,000
Health Care Plus*	Network	3	40,000
Health Plan of Mid-America	IPA	1	3,000
Kansas City Health Care**	Staff	1	<u>9,000</u>
TOTAL			187,055

* Headquarters in Wichita, Kansas. Only a portion of its members reside in the Kansas City Metropolitan area.

** Recently purchased by Kaiser.

Source: Telephone calls with membership departments of each plan.

Employers and other purchasers in Jackson County have begun to take an active role in health care cost containment through participation the Mid-America Coalition on Health Care. The Coalition, which is composed of employers, unions, and insurers, recently mounted a six-week public education campaign dubbed "Health Vote." Health care cost problems were communicated via television spots, brochures, town meetings, and a television special. The campaign culminated with a ballot in the local paper asking citizens to vote on options for controlling health care costs.

With price competition increasing in Jackson County, the problem of care for indigent populations has become a highly publicized issue, particularly since the burden of indigent care appears to be borne by fewer and fewer institutions. Two of the largest providers, Truman Medical Center and Children's Mercy Hospital, are concerned that cost containment efforts by the state and private purchasers will squeeze their revenues further, making them even less able to care for indigent patients. County budget allocations for indigent care have tightened and will not adequately fill the gap. These hospitals have organized a study group to document the problem. In addition, the indigent care problem has attained statewide recognition, thanks in part to educational efforts by the Missouri Hospital Association and the Governor's Task Force on Health Care Costs.*

Competitive pressures and some of the deleterious side effects -- i.e., threats to care for the poor and uninsured -- may influence the success of the MHCP. Some of the participating hospitals and health centers believe the MHCP may contribute to their financial instability, particularly if the state reduces capitation rates in the future. Further, although they support the Medicaid demonstration in principle, the providers are concerned that the

* Missouri Governor's Task Force on Health Care Costs, December 1984.

capitation rates may be inadequate to support medical education and indigent care. At the same time, participating hospitals and neighborhood health centers acknowledge that the MHCP has allowed them to gain experience with prepayment. Now that they are more comfortable with risk management, some of these providers are considering marketing to the private sector.

D. CHANGES IN MISSOURI MEDICAID PROGRAM

In 1982, a Medicaid budget crisis forced Missouri to restructure its Medicaid program. The restructuring shifted utilization from skilled nursing facilities and hospitals to less costly settings, including physicians offices and the home. As a result, Missouri was able to keep the rate of increase in Medicaid program expenditures to 8 percent in FY 1982, following a 24 percent increase the year before. In FY 1983, the state again experienced a small increase of 8.3 percent. In FY 1984, Missouri made a number of minor adjustments to the Medicaid program, such as expansion of the second surgical opinion program, mandating outpatient surgery for certain procedures, and updating prevailing fee schedules for physicians. These changes enabled Missouri to constrain Medicaid expenditure increases to 9.3 percent (Table II.3). Expenditures in Jackson County in FY 1984 were \$53 million or about 12 percent of the statewide total of \$433 million. State expenditures for AFDC recipients, which are by far the largest Medicaid group (63.7 percent of all eligibles), represented 23.6 percent of total expenses in FY 1984 (Table II.4).

Most of the Medicaid policy changes adopted in the past year and a half restrict the scope of coverage or increase patient cost-sharing. For example, as of December 1, 1984, recipients aged 18-21 now face the same copayments as adults (i.e., \$10 for inpatient admissions and \$2 for outpatient care and \$1 for physician services). Beginning in 1985, the state is also moving to a fee schedule (based on a percentage of charges) for reimbursement of certain clinical diagnostic laboratory services in outpatient hospitals. Hospitals

TABLE 11.3

SUMMARY OF MISSOURI MEDICAID EXPENDITURES
(In Thousands)

	FY_1981_	%_Change	FY_1982_	%_Change	FY_1983_	%_Change	FY_1984_	%_Change
Hospital								
Inpatient	\$100,730	18.5%	\$103,499	2.8%	\$112,900	9.1%	\$121,777	7.9%
Outpatient	--17,230	-16.5%	--24,146	-40.1%	--28,130	-16.5%	--22,488	(20.1%)
	\$117,960	18.2%	\$127,645	8.2%	\$141,030	10.5%	144,265	2.3%
Nursing_Home	131,018	22.8%	155,583	18.8%	175,839	13.0%	192,418	9.4%
Physician/Clinic	29,130	35.0%	30,118	3.4%	31,012	3.0%	36,261	16.9%
Other	--61,256	-31.4%	53,183	(13.2%)	--49,061	-(9.2%)	--60,873	-24.1%
Total	\$339,364	23.6%	\$366,529	8.0%	396,942	8.3%	433,817	9.3%

Source: Missouri Department of Social Services, Budget documents, FY 1984 and information prepared by
Missouri Division of Medical Services, May 1985.

TABLE II.4
DISTRIBUTION OF MISSOURI, MEDICAID RECIPIENTS
AND PAYMENTS BY ELIGIBILITY CATEGORY
FY 1984

<u>Category of Assistance</u>	<u>Eligibles</u>		<u>Payments</u>	
	<u>Number</u>	<u>Percent</u>	<u>\$ (Million)</u>	<u>Percent</u>
AFDC	196,761	63.7%	\$122,145	23.6%
Aged	53,406	17.3	215,863	41.8
Blind	1,521	0.5	3,732	0.7
Disabled	42,458	13.7	156,313	30.2
Other Title XIX	4,452	1.4	7,754	1.5
State Only	10,318	3.4	11,145	2.2
TOTAL	308,916	100.0%	\$516,952	100.0%

Source: Missouri Department of Social Services, May 1985.

are no longer allowed to "combine bill" professional fees with inpatient hospital expenses. Professional fees are now billed separately and reimbursed according to a fee schedule. Finally, approximately 500 surgical procedures that can be performed safely out of the hospital are now reimbursed only when provided in an outpatient setting.

At the same time, some Medicaid benefits and reimbursement levels were improved in FY 1984. For example, prenatal vitamins were added to the pharmaceutical formula. A drug exception process for non-steroidal anti-inflammatory drugs was expanded. Lengths of stay for certain children's diagnoses were raised. Further, at a cost of \$2 million in FY 1984, the state increased reimbursement for various physician procedures. When Missouri compared its prevailing fees to Medicare fees, it became apparent that procedures performed by certain specialists, notably radiology and surgery, were more than 25 percent below comparable Medicare fees. The update now brings Missouri significantly closer to private fee structures. (This change follows upon adjustments of primary care reimbursement. Two years ago, the state significantly increased physicians fees for office visits, including evening office visits, and also placed restrictions on emergency room and outpatient hospital visits.)

CHAPTER THREE

STATE IMPLEMENTATION AND OVERSIGHT

A. INTRODUCTION

In the past year, the state Prepaid Health Unit has concentrated on solving problems associated with demonstration start-up, developing reporting procedures, and monitoring the prepaid plans and physician sponsors. This chapter chronicles these activities, including:

- project management,
- enrollment and marketing,
- quality assurance,
- financial reporting and audits,
- administration and management information systems,
- ratesetting for PHPs, and
- future developments.

B. PROJECT MANAGEMENT

In 1982, the Department of Social Services formed a Prepaid Health Unit to plan and implement the demonstration. The Unit has had four directors since its inception. The first director left for personal reasons after a few months. The second director was Mr. Robert DiPrete, who stayed 17 months, until the project was operational. His successor, Ms. Linda Logsden, assumed the job on a part-time basis in March 1984 while also serving as Associate

Director of the Medicaid program. In August 1984, the Prepaid Health Unit was integrated into the Policy Unit of the Medicaid program and Ms. Helen Clarkston, an Assistant Medicaid Administrator, was appointed Acting Director of the Unit. Eleven months later, in June 1985, Mr. Ron Meyer was appointed Director of the Prepaid Health Unit. He now reports to Ms. Marva Lubker, Deputy Director of the Division of Medical Services. The MHCP is now the major program in the Policy Development section of the Division of Medical Services. (Figure III.1 provides an organizational chart of the Division of Medical Services and the MHCP's role within the Division). The high turnover within the Prepaid Health Unit has not hindered implementation of the demonstration. However, several participating PHPs are concerned about the lack of continuity at the state level.

The decision to merge the Prepaid Health Unit with the general Medicaid program is part of a long-range plan to convert the demonstration to a permanent program. To accomplish this, the state will propose extension of the demonstration waivers for an indefinite time period.* Missouri will argue that both the Medicaid division and the PHPs have made significant investments in start-up of the demonstration with the expectation that it will endure if successful.

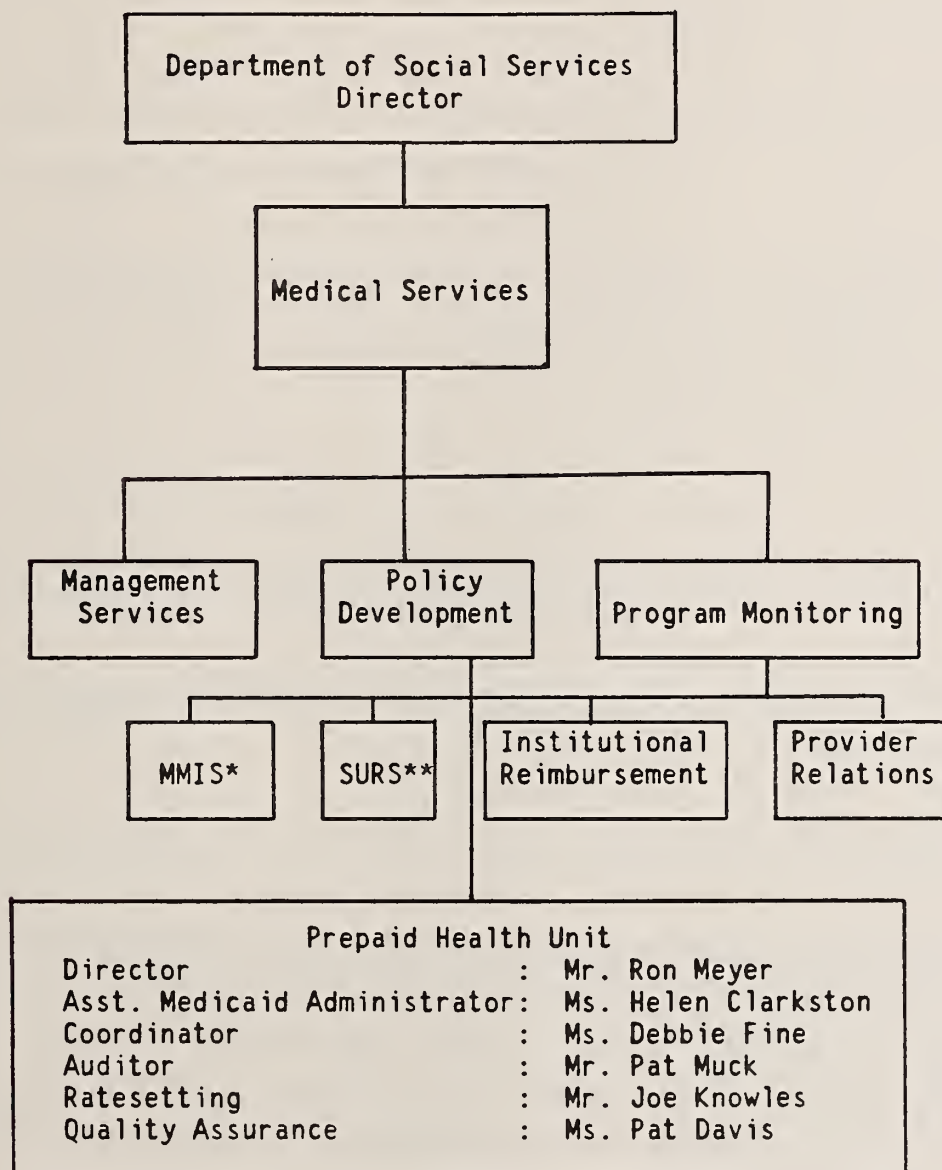
C. ENROLLMENT AND MARKETING

As of March 1, 1985, the MHCP enrollment was virtually completed, with 24,207 AFDC recipients enrolled. In addition, approximately 2,000 recipients have not yet been enrolled because they failed to respond to a letter asking them to come to the Jackson County Department of Social Services office to select a PHP or physician sponsor. The state contacted them to reschedule an

* Since the Medicaid Section 1115 demonstration waivers are not permanent, the state may be forced to reapply under different statutory authority (e.g., Section 1915b of the Medicaid Statute).

FIGURE III.1

PREPAID HEALTH UNIT AND MISSOURI MEDICAID DIVISION:
ORGANIZATIONAL CHARTS



Source: Missouri Department of Social Services, May 1985.

- * Medicaid Management Information System
- ** Surveillance and Utilization Reporting Systems

appointment. Another 800 recipients are unemployed parents who are now being enrolled but who were initially excluded because the state lacked adequate utilization data for setting rates. Thus, eventually, total enrollment will be approximately 27,000.

1. Enrollment Process

MHCP enrollments are conducted by the Jackson County office of the Department of Social Services. AFDC recipients attend group presentations conducted by one of three trained Medicaid Choice workers. The Choice workers distribute information materials on the health plans and physician sponsors and present a slide show emphasizing consumer choice. The process is designed to assure that the information presented about the MHCP is objective and accurate.

When MHCP first began in November 1983, Choice workers enrolled only new AFDC applicants. As of March 1984, the MHCP began enrolling current AFDC recipients at the time they recertify their eligibility for AFDC and Medicaid. Initial enrollment for MHCP must be performed in person. Thus, all AFDC recertification clients were notified about the MHCP and invited to attend a Choice presentation.

By summer 1984, the Choice office was processing 1,000 people per week. According to Ms. Patricia Pacheco, Choice office supervisor, the paperwork and filing proved to be an extreme burden for the staff, which included one clerk and two clerical personnel. Therefore, another Choice worker and a temporary clerk were recruited to assist. However, even with additional help, the Choice office was unable to handle the workload. In September, the state began assisting the county with correspondence, scheduling of appointments, and completion of enrollment.

The enrollment process for AFDC clients facing recertification involved several steps. Initially, 9,000 AFDC caseheads received a letter asking them

to schedule an appointment to attend a Choice presentation. About 2,400 recipients failed to comply and received a second letter notifying them that they were scheduled to attend the presentation on a particular date. Recipients who did not respond to the second letter (1,360 in total) were randomly assigned to a PHP.

A significant number of problems associated with enrollment have arisen during the first year of operations, many of which were unanticipated during the planning stage. These included the following:

- Eligibility terminations: AFDC recipients must report to their case worker each month in order to retain eligibility. If they fail to submit their monthly report on time, their case is closed. However, if they comply quickly by submitting a late report, the case worker can "cancel the closing". In order to reenroll these recipients who are "cancel closed", a computer program was developed to list all Jackson County AFDC recipients so appropriate action can be taken to correct MHCP enrollments.
- Physician disenrollment: When a physician withdraws from the PSP, the county Choice Office must notify his or her enrollees and ask them to come in to make another selection.
- Enrollment of newborns: If a woman selects a PHP and has a baby while enrolled, her baby is automatically enrolled in that plan on the date of birth. In contrast, if she selects a physician sponsor, she may choose any provider she wishes for her baby. The Choice Office requests her to make a selection for the baby, and, if no choice is made, assigns the baby to the plan selected for other family members.
- PHP enrollee hospitalized on the date enrollment is effective: All MHCP enrollments become effective at the beginning of the following month. Occasionally, a recipient is in the hospital on the date PHP enrollment is effective. In this instance, the program pays fee-for-service Medicaid rates for the hospitalization and recoups the capitation amount from the PHP, effectively delaying enrollment until the hospitalization is over.
- Random assignment of recipients who do not make a choice: AFDC recipients who do not attend a Choice presentation are randomly assigned to a PHP. The PHPs have complained that random assignment of recipients has led to out-of-plan use by individuals who do not understand the program. Analysis of out-of-plan users indicates that the majority have not been assigned. Thus, the state plans to continue its random assignment policy.

The county Choice Office has no plans to encourage PHP enrollees to make another selection after the initial six-months enrollment period that is guaranteed to the plan. They are concerned that if a choice were actively promoted, enrollees would feel compelled to make a change. As the director of the state Prepaid Health Unit said, "The value of the program is that recipients can stay with a particular provider, and we don't want to disrupt that continuity."

2. Marketing

PHPs are permitted to market directly to Medicaid recipients. However, their marketing materials must be approved in advance by the state. The state marketing guidelines require materials to be factual and to emphasize distinguishing characteristics, such as additional benefits. Door-to-door solicitations are not allowed, but PHPs are permitted to send letters to current Medicaid clients. The state has also offered to do a mass mailing for health plans if they will cover postage cost and provide all mailing materials.

PHPs and physician sponsors have conducted little marketing to date. Most PHPs have posted signs in their waiting rooms which describe the plan and encourage patients to enroll. One neighborhood health center has made presentations to church groups. Other plans have mailed plan brochures to current patients.

A few plans are dissatisfied with the state's oversight of advertising copy and would like greater freedom to solicit patients. Although marketing was not a pressing issue during the first year when plans were focused on operational start-up, several plans predicted that it will grow in importance over the next year as competition intensifies.

D. QUALITY ASSURANCE

In the past year, the state has developed quality assurance procedures which are tailored to the incentives inherent in the PHP and PSP. In addition to general monitoring of quality of care, the state will attempt to discern under-utilization among PHPs and over-utilization among physicians in the PSP.

In February 1985, a nurse was hired to direct the state's quality assurance activities. She has extensive clinical experience but no actual background in this quality assurance area. She has immersed herself in the quality assurance literature and is working closely with the Medicaid Surveillance and Utilization Reporting Systems (SURS) unit. With their help, she has developed a series of MHCP quality assurance activities that are intended to complement, and in some instances, augment existing SURS utilization review functions, which involve analyses of summary claims data and medical records to detect misutilization of services.

Monitoring of physician sponsors includes:

- review of SURS output on recipient utilization patterns to determine whether case management has occurred, referrals have been used appropriately, treatments are consistent with diagnoses, and the extent of "out of plan" use.
- review of SURS-generated data which rank utilization of all physicians, in order to compare physician sponsors with their peers.
- review of claims by individual physician sponsors to detect utilization patterns.

Monitoring of PHPs includes:

- audits of medical records to verify compliance with the PHPs' own standards and protocols.
- review of PHP referrals to identify whether use of specialists is unusually low.

- review of inpatient statistics to identify abnormal utilization.
- review of quarterly reports submitted by the plans to account for volume and the mix of services provided.
- review of SURS-generated reports on utilization by recipients and providers to determine whether utilization is appropriate.
- review of PHP quality assurance procedures to determine whether an internal system is in effect and includes dedicated staff, written policies, and physician participation.

Other quality assurance procedures have been instituted including:

- Patient satisfaction and complaints: Once a year, in conjunction with on-site audits of PHPs, the state will field a health satisfaction survey for enrollees. The survey measures enrollee perceptions of health care they have received from the various PHPs. All participating PHPs receive copies of surveys and the quality assurance staff analyze the results. Responses which suggest quality problems are investigated. To date, survey results indicate that, by and large, patients are satisfied with the PHPs. In addition, during on-site audits, patients are interviewed about the care they receive. Finally, twice a year, recipients are notified about procedures to follow if they have complaints about their health care.
- Reasons for transfer: All recipients who request a transfer are asked to list their reasons on a form which is analyzed by the state. All suspected quality problems are investigated. As of August 1985, 94 investigations of reasons for transfers have been initiated. Of these, 68 are open and 26 have been closed. At intervals during the year, transfer statistics are compiled and analyzed to detect problems such as provider "dumping" of high risk recipients.
- High risk enrollments: During the enrollment process, all caseheads complete a health status questionnaire for their entire family which queries about pre-existing medical conditions. The state notifies the appropriate physician or PHP about all high risk enrollments and encourages early evaluation of these individuals. During on-site audits, the state may flag these patients for thorough review of the quality of care they are receiving.

- Twenty-four hour availability: The PSP and PHP contracts require physician availability around the clock. On a quarterly basis, physician sponsors and PHPs are telephoned after office hours to ensure that either an answering machine or recorded message is available to help patients reach a physician in emergencies. A log is kept of these contacts. With the assistance of the SURS unit and the Division of Investigations, procedures have been developed to deal with participants who repeatedly do not comply with the contract. For example, it became apparent that physician sponsors did not clearly understand their obligations regarding round-the-clock availability. A clarifying bulletin was sent to all physician sponsors.
- Onsite audits: Two PHPs have been audited to date. The audit team reviewed the following areas: grievance systems, discharge planning procedures, medical protocols for a number of routine diseases and procedures, arrangements for emergency care and specialty referrals, and procedures for following up missed appointments. In addition, auditors inspected the facilities and reviewed medical records. (In the future, the state will also audit medical care using disease-specific protocols.) Audit findings are sent to PHPs with recommendations for corrective action. Post-audit reviews are then conducted to determine whether corrective actions have been effective.

Next year, the state quality assurance staff plan to emphasize patient education. Future contracts will require PHPs and physician sponsors to provide recipients with information about maintenance of good health and the proper use of the health system. All contractors will be required to document these activities.

E. FINANCIAL REPORTING AND AUDITS

The Prepaid Health Unit developed financial reporting and audit procedures through a consultative process with each of the prepaid plans. This section chronicles the development process, describes the reporting forms and audit procedures, and presents the various uses of these reports.

1. Quarterly Cost and Utilization Reports

In March 1984, the Prepaid Health Unit developed a draft cost and utilization report format that was patterned after reports used in a California prepaid project known as PHRED. The draft was shared with PHPs at a meeting in June. Revisions were made, and a final reporting form was mailed to all plans in October 1984. The plans submitted the first batch of reports in December. Data for the first three quarters of 1984 are now complete. The reports are as follows:

- **The Quarterly Utilization Report:** This report compares utilization for the quarter with total utilization during the year to date. Use rates are expressed in hospital days and visits per 1,000 enrollees. Plans are asked to report number of services and visits for specific categories of service. In addition, plans must report audit adjustments and utilization of medical services for which billings have not yet been received (e.g., specialty or other contract services).
- **The Quarterly Medical Services Cost Report:** This report accounts for the cost of all categories of medical services provided during a three month period. The costs are reported as follows: (1) costs for services provided directly or contracted by the plan; (2) out-of-area or unanticipated services; (3) estimates incurred, but billings not yet received; (4) billings to third parties (e.g., insurance proceeds); and (5) total costs. These costs must be reported for each category of covered services.
- **Quarterly Administration Cost Report:** This report requires PHPs to allocate a portion of general and administrative expenses to the MHCP.
- **Quarterly Utilization and Cost Report Summary:** This report is used to compute plan cost and utilization per member month. These statistics are compared to projected plan costs and utilization. This report allows the state to assess whether the plan is solvent.

2. Financial Audits

In October 1984, the Prepaid Health Unit hired an auditor and retained several outside consultants. As of March 1985, they had completed on-site

financial audits for four of the PHPs. Each audit took a week to perform and covered a 9-month period: January 1984 through September 1985. One of the PHPs, the University of Health Sciences, initially was reluctant to submit quarterly reports, claiming that accounting staff were unavailable. The state is helping the plan complete the reports and plans to perform an audit in late spring.

The first round of audits focused on each plan's cost accounting methods. Specifically, the auditor examined the general ledger to determine if charges had been posted properly. According to the auditor, costs reported for the first three quarters of 1984 are not comparable across plans. Until the data are made more uniform, quarterly report information will not be released to the public. In particular, plans do not account for administrative costs uniformly. Further, Prevention Plus capitates laboratory and psychiatric services and does not receive utilization reports from these providers. Therefore, it can report expenses but not the amount of services delivered.

3. Use of Audited Quarterly Reports

When complete and comparable quarterly reporting data are available, the state will look for aberrant utilization patterns. For example, plans with exceptionally low inpatient days per 1,000 enrollees may be flagged for review. In addition, quarterly report data are slated to be used for development of plan-specific capitation rates. The MHCP protocol calls for replacing the current county-wide capitation rates with individual rates calculated from each plan's experience.

Due to data reporting problems (described above), the state is reluctant to release quarterly report findings for the first nine months of MHCP. In addition, total enrollment was small, and out-of-plan use occurred frequently

during this period. Consequently, the state is cautious about interpreting initial findings, which indicate that plans may be "making money" due to reductions in hospitalizations.

F. ADMINISTRATION AND MANAGEMENT INFORMATION SYSTEMS

To administer the MHCP, Missouri decided to use existing Medicaid management systems. This decision was made to minimize expenditures for new systems and to ensure that the demonstration could easily be incorporated into Medicaid when it became a permanent program. The state worked with General American Consultec, the Medicaid fiscal agent, to design a new computer subsystem of the Medicaid Management Information System (MMIS). An enrollment subsystem was also developed for the Income Maintenance data base.

The Income Maintenance data base contains files on all Medicaid recipients. The new subsystem permits the state to maintain an up-to-date list of all demonstration enrollees, their date of enrollment, and plans or providers they have chosen. Daily, the Jackson County Department of Social Services transmits information on new enrollees and their choices to the state prepaid health data base. The enrollment data are then transferred on a daily basis to the state's MMIS recipient subsystem for claims processing and reimbursement.

The MMIS claims processing system issues physician sponsors a check for their case management fees (\$1.50 per enrollee per month) as well as reimbursement for fee-for-service claims. PHPs are issued a check for their monthly capitation payment according to the number of enrollees in the MMIS file. The check is accompanied by a "remittance advice" which lists the names of all enrolled recipients and amount of capitation payments.

Specific modifications to the MMIS claims processing system are described below.

1. Pseudo Claims

PHPs are required to submit non-payable (pseudo) claims for all services rendered to enrollees. These pseudo claims are standard Medicaid claim forms (for inpatient, outpatient, and professional services) but are not used for reimbursement purposes. Thus, many of the edits and audits applied to fee-for-service claims are not applied to the pseudo claims. Rather, these claims enable the state to calculate what program costs would have been under the regular Medicaid fee-for-service system and to perform quality assurance and utilization reviews.

During the first two quarters of the demonstration, the state conducted internal testing of new procedures for processing pseudo claims. In October 1984, staff from each of the plans were trained in the new procedures. Thereafter, claims began to trickle into the system, and submissions are now up to "full force."

Now that the pseudo claims processing system is operating smoothly, the state has asked plans to submit, retrospectively, all claims for services rendered during the early months of the demonstration. Plans will also be asked to resubmit all claims that have been "denied" but are correctable. Usually, denials occur if information is missing or inconsistent (e.g., improbable dates of service, incorrect procedure code.) In the fee-for-service system, these claims are usually resubmitted and paid. In the early weeks of pseudo claims submission, the Medicaid Provider Relations Unit assigned a technician to screen PHP pseudo claims for completion and accuracy before submission to processing. The plans were advised of any billing errors

detected during the screening process. The technician was available to answer questions and has been working with plans to help them correct denied claims. A provider relations representative is also available to assist PHPs with billing problems.

Once a complete pseudo claims file has been created, the Prepaid Health Unit plans to use the SURS system to develop their own computer programs for analyses of utilization and costs. In addition, the Prepaid Health Unit plans to compare utilization experience in the MHCP with experience in other parts of the state and with previous experience in Jackson County.

2. Payable Claims

In addition, the MMIS claims processing subsystem was reprogrammed to deal with three elements of the MHCP. First, the system ensures that fee-for-service payments are made for services not covered by PHPs (e.g., outpatient pharmaceuticals). Second, the system denies claims submitted by out-of-plan providers for services which are covered by the PHPs. When the claim is denied, the MMIS explanation of benefits form will instruct the provider to resubmit the bill to the patient's PHP. Third, the system denies reimbursement to specialists if claims submitted on behalf of PSP enrollees are not accompanied by a referral form. Extensive testing over a six-month period was required to correct and validate the MMIS system.

6. RATESETTING FOR PHPs

The base rate for the MHCP is set at 90 percent of what the state would have paid per enrollee per month under the Medicaid fee-for-service program. Two age classes have been established: AFDC adult (case head), which is currently \$83.35 per month and child (dependent), which is \$39.34.

These rates were set according to an analysis developed by Actuarial Research Corporation. (This company is a subcontractor to the state's

ratesetting consultants, Jurgovan and Blair, Inc.). Presently, the Prepaid Health Unit is working with Jurgovan and Blair, Inc. to develop new rates for FY 1986 (July 1985 through June 1986). The ratesetting methodology contains several refinements which should make the rates more precise. The current ratesetting methodology is described below and, where appropriate, improvements that will be made for the FY 1986 ratesetting cycle are also described.

The capitation rate for FY 1985 is based on a fee-for-service equivalent calculated from statewide paid claims data, using FY 1982 as a base year. First, the 1982 paid claims data for Missouri as a whole are broken down into average cost per unit of service by type of service (inpatient and outpatient hospital, physician, drugs, x-ray, etc). The cost for each of these service categories is reported on a per capita basis for AFDC recipients (Column 1, Table III.1).

Second, a couple of billing adjustments are made. First, an adjustment is made for "lump sum settlements," which represent for selected service categories the difference between actual expenditures and the interim payments made to providers. In addition, an adjustment is made for a "lag factor," i.e., costs of claims incurred during the year but paid the following year (Column 2, Table III.1).

Third, a geographic adjustment is made to the resulting per capita costs. Specifically, the hospital cost portion of the rate was assumed to be 14 percent higher in Jackson County than for the state as a whole. (Columns 3 and 4, Table III.1).

Fourth, the costs for each service category (excluding drugs and dental, which are optional benefits under this program) are trended forward. The trend factors used are a combination of actual price and utilization changes in FY 1982 and FY 1983, and assumptions for post-FY 1983. Hospital prices

were assumed to increase 9 percent annually to January 1984, due to changes in intensity of services and price increases allowed for certain hospitals. The CPI was used as the price factor for all other types of services, except outpatient hospital, which was reduced 2 percent annually to account for copayments. Changes in utilization were based on historical experience. (Column I, Table III.2).

Since January 1984, the fee-for-service costs have been updated twice, in July 1984 and again in January 1985 (Columns 2 and 3, Table III.2). The current composite rates represent only a slight increase over the previous year. The difference is due to the trend factors (described above). For example, Medicaid fee increases for physician procedures and for other services added approximately \$.26 per capita each month. By summing the per capita costs by service, a composite fee-for-service equivalent is produced (Table III.2).

Fifth, the composite fee-for-service equivalent is broken into rates for adult and child eligibility categories. Children represent about half of the total claims expenditures by service, and (in FY 1982) constituted about 68 percent of all AFDC recipients. For most services, the child rate is derived by multiplying the composite (per service) (\$59.31) by $(0.50/0.68)$. Similarly, the adult rate is derived by multiplying the composite per service times (\$59.31) times $(0.50/0.32)$. Exceptions are made for the "other" and "EPSDT" categories, since most of these costs are allocated to the child rate. For the "Family Planning" category, virtually all costs are allocated to the adult rate.

Sixth, the capitation rate is calculated by taking 90 percent of the rates described above for children and adults, i.e., \$39.34 and \$83.35. Charges for two mandatory risk limiting pools (described below) are then subtracted from the base rate. The result is a final base capitation rate for the eligibility groups (Table III.3).

TABLE III.1

MISSOURI MHCP RATE SETTING
(Development of FY 1982 Incurred Per Capita Cost)

<u>Service</u>	(1) Unadjusted FY 1982 Expen- ditures	(2)* Billing Adjustment	(3) Geographic Adjustment	(4) Jackson County
Physician	\$ 5.47	\$ 5.59	1.00	\$ 5.59
Inpatient	26.23	28.37	1.14	32.31
Drugs	2.09	2.09	1.00	2.09
Outpatient	6.82	7.32	1.00	7.32
Dental	3.20	3.19	1.00	3.19
X-Ray/Lab	.24	.26	1.00	.26
Ambulance	.08	.10	1.00	.10
Optometry	.52	.51	1.00	.51
Clinic	1.78	1.86	1.00	1.86
DME	.08	.10	1.00	.10
Audiology	.01	.01	1.00	.01
Podiatry	.02	.02	1.00	.02
Family Plan	.96	.81	1.00	.81
EPSDT	.25	.25	1.00	.25
HHS	.02	.02	1.00	.02
Other	.12	.12	1.00	.12
TOTAL	\$47.89	\$50.61	1.08	\$54.56

* Adjustments for billing problems included: (1) lump-sum settlements for providers whose experience varied from the Medicaid interim payment rate, and (2) billing lags for claims incurred in FY 1982, but not paid until the next year.

Source: Tillinghast, Nelson, and Warren, Inc., "Missouri Medicaid Demonstration Ratesetting and Reimbursement," January 1985.

TABLE III.2

MISSOURI MHCP FEE-FOR-SERVICE EQUIVALENTS

<u>Program</u>	(1) March 84 (Midpoint)	(2) July 84	(3) January 85
Physician	\$ 6.71	\$ 7.10	\$ 6.74
Inpatient	37.55	38.62	39.02
Outpatient	8.96	9.06	9.05
X-Ray/Lab	.33	.33	.33
Ambulance	.06	.06	.06
Optometry	.64	.67	.64
Clinic	1.85	1.85	1.85
DME	.09	.09	.09
Audiology			
Podiatry	.01	.01	.01
Family Planning	1.05	1.05	1.05
EPSDT	.32	.32	.32
HHS			
Other	<u>.15</u>	<u>.15</u>	<u>.15</u>
Composite Fee-For- Service Equivalent	\$57.72	\$59.31	\$59.31

Source: Tillinghast, Nelson, and Warren, Inc., "Missouri Medicaid Demonstration Ratesetting and Reimbursement," January 1985 and Missouri Department of Social Services, 1985.

TABLE III.3
MISSOURI MHCP RATE SETTING
FY 1985

	<u>PHP Basic Capitation</u>	<u>Adult</u>	<u>Child</u>
(1) Total Fee-For-Service Equivalent		\$92.61	\$43.71
(2) 90% of (1)		83.35	39.34
(3) Pooling charge for Excessive Maternity and Neonatal Stays		2.26	2.26
(4) Pooling charge for Excessively High Frequencies of Deliveries		1.00	1.00
(5) Basic Capitation Rate (2) - (3) - (4)		\$80.09	\$36.08

Source: Tillinghast, Nelson & Warren, Inc., "Missouri
Medicaid Demonstration Ratesetting and Reimburse-
ment," January 1985.

The state requires PHPs to participate in reinsurance pools for certain types of services. A portion of the base (90 percent) capitation rate is deducted in exchange for their protection. The three mandatory risk limitations include:

- **Long-Term Maternity and Neonatal Stays:** The state agreed to protect PHPs from financial exposure for high risk deliveries and neonatal intensive care. The base capitation rate is be reduced by \$2.26 per member per month for maternity and newborn hospital stays in excess of 9 days. The state pays fee-for-service Medicaid rates for patients who stay more than 9 days.
- **Adverse Selection Due to Enrollment of a Disproportionate Number of High Risk Enrollees:** The state elected to protect plans against excessive hospital use by patients with chronic disease or other high risk illnesses. The state identifies high risk patients by administering a health status questionnaire to all AFDC recipients at the time of enrollment. For each high risk enrollee in the PHP, Medicaid places 5 percent of the monthly capitation rate into an adverse selection fund. At the end of the year, Medicaid reviews each plan's experience and pays for hospital days in excess of a target level (700 inpatient days per 1,000 enrollees) up to the amount in the fund. If the fund is not sufficient to cover excess hospital days, the PHP absorbs the loss.
- **Hospital with High Delivery Rates:** Several plans were concerned that they would attract a disproportionate number of pregnant women (or women who planned to become pregnant) and, thus, adversely affect their experience.* As a result, a formula was developed that protects PHPs for deliveries in excess of 105 percent of the average delivery rate for participating PHPs. A risk pool has been created that is jointly funded by a monthly state contribution of \$30,000 and a deduction from the base rate of \$1.00 per member per month. At the end of each contract period, delivery frequencies are calculated both for individual plans and for all plans. The plan(s) with delivery rates that exceed 105 percent of the overall frequency draw against the risk pool at a rate of \$1,200 per excess delivery. Initially, payments will be made from the state's monthly contribution. The plans are financially liable for delivery-related costs in excess of the amount in the risk pool. If any portion of the plan's part of the risk pool is available at the end of the year, it is distributed among the plans according to their relative contributions.

* Truman Medical Center was particularly concerned because, traditionally, 65 percent of all AFDC deliveries in Jackson County have occurred in its obstetrical unit.

In addition to mandatory risk pools, the state has established two optional risk limitations. The first is a catastrophic stop-loss arrangement whereby the state pays for annual per-recipient costs above \$20,000 of Medicaid-allowable fee-for-service reimbursement. For this reinsurance protection, \$2.11 per member month is deducted from the base rate. Although all plans elected for this protection, to date only one plan has used the stop-loss provision. The second optional risk protection is for third party recoveries. Under this provision, PHPs lose \$0.27 per member per month in return for the right to collect and retain payments from the AFDC recipients' private insurance. Four plans have elected this provision.

For setting FY 1986 rates, the state will use a complete sample of monthly incurred AFDC claims for Jackson County, using FY 1983 as a base year. A more sophisticated methodology will be used to calculate the rates.

In FY 1987, plans call for development of facility-specific rates calculated from PHP quarterly cost and utilization data. The state will estimate expected utilization for each PHP based on enrollment mix. In addition, the state will compute a fee-for-service equivalent for Jackson County using AFDC data from similar counties in other parts of Missouri.

H. FUTURE DEVELOPMENTS

The state is interested in expanding the MHCP to other parts of the state. St. Louis City, where about 55-60,000 AFDC recipients are enrolled in Medicaid, has been suggested as a possible location. Early indications suggest that several providers in St. Louis would be interested in capitation contracts. The state may begin to draft legislation and a waiver proposal in the near future.

CHAPTER FOUR

PHP AND PSP ACTIVITIES

A. INTRODUCTION

Each prepaid plan and physician sponsor has adapted to the new demonstration in a distinctive fashion. As is the case with most new programs, problems arose during early implementation, but operations are now progressing more smoothly. Several prepaid plans have invested in new management systems and personnel, with the expectation the Medicaid demonstration will become permanent. Several plans are also considering expanding into the private HMO market. The physician sponsors, by and large, continue to operate under the demonstration as if it were "business as usual." In the future, the key issue is whether the participants will change their practice patterns and begin to compete for patients. Early signs indicate that marketing may intensify over the next year.

This chapter first profiles the operations of PHPs and PSPs and then reports specific problems that arose during the first year of the demonstration.

B. OPERATIONS OF PARTICIPATING PHPs AND PSPs

1. Truman Medical Center

Truman Medical Center continues to provide the majority of health care for the AFDC population in Jackson County. The hospital plays a dual role

under the MHCP: First, it sponsors a PHP. Truman Medical Center provides comprehensive services for adult enrollees and Children's Mercy Hospital provides primary and tertiary care to enrolled children under a subcontract whereby it shares in the state's capitation payments on a prorated basis. As of August 1985, the Truman PHP had the largest share of MHCP enrollments -- 7,835 recipients or 34 percent of the total AFDC population. According to the Deputy Administrator at Truman Medical Center, this enrollment reflects historical market share. Second, Truman Medical Center is a subcontractor for inpatient care provided to enrollees in the neighborhood health center PHPs. Approximately 5,000 neighborhood health center PHP enrollees (21 percent) can receive hospital care at Truman Medical Center and Children's Mercy Hospital.

The primary mission of Truman Medical Center is to provide health care for indigent populations and to train medical personnel. The Medical Center is one of the largest providers of health care to low income residents in Jackson County. Medicare, Medicaid, and General Relief account for over 80 percent of its patient revenues. The Medical Center also serves as the major training facility for the School of Medicine of the University of Missouri-Kansas City. These activities have higher priority than the MHCP. As the Deputy Administrator, Mr. Dan Couch, stated, "We do not see ourselves as a competitive HMO all of a sudden; we do not want to lose any paying patients, but we must keep in mind our commitment to our public mission -- to train medical professionals and to treat the poor."

Consequently, Truman Medical Center has chosen not to make major organizational changes in response to the demonstration. For example, it has not formally oriented the medical staff about the incentives in the new program nor has it added any special utilization review protocols. Further, partly to keep financial management and accounting simple, Truman decided not

to give its non-profit physician group practice or hospital departments a financial stake in the success of the plan. Rather, the Medical Center allocates capitation revenues based on services rendered, using Medicaid fee-for-service rates as the basis for allocation.

Nevertheless, Truman Medical Center believes it is making money under the demonstration because inpatient hospitalization has been reduced. They believe that AFDC participants are averaging 700 days per 1,000 enrollees compared to a target of 800 days. (This compares to reports of 300-400 days per 1,000 enrollees reported by other plans). It is not known how much of the reduction is due to out-of-plan use by enrollees. Some of the decline may also be due to changes in the environment, such as the advent of DRG. Indeed, average lengths of stay have been steadily dropping for all patients from a high of 5.8 in October 1984 to 4.5 days in winter 1985. The Medical Center administration conjectures that physician practice patterns are changing, and the patient mix has improved. They argue that the physicians already know that they cannot overuse resources in an institution with serious budget constraints.

In its role as a subcontractor to the neighborhood health center PHPs, Truman Medical Center has devoted considerable resources to implementing referral procedures. Development of these relationships has been relatively smooth, since Wayne Miner has operated an obstetrical service in the hospital for several years, and Swope Parkway medical staff have admitting privileges. In addition, considerable time was spent obtaining prior authorization from neighborhood health centers and physician sponsors so that Truman Medical Center could be reimbursed for specialty care.

2. The University of Health Sciences

Of all the plans, this 284-bed osteopathic hospital has had the greatest reservations about participating in the demonstration. Essentially, the hospital decided to participate primarily to maintain its market share. However, the hospital administration is concerned about the administrative

burdens involved. Further, the hospital is disappointed that such a small number of enrollees -- 2,424 or 10.6 percent of the AFDC population as of August 1985 -- have selected the plan. In prior years, over 7,000 AFDC recipients used the hospital's clinics, and they had hoped to enroll as many as 10,000 recipients (20 percent) under the demonstration. Although the University of Health Sciences is currently breaking even, hospital representatives said they might withdraw from the program if it begins to lose money.

The health plan is now being administered by the deputy hospital administrator, who inherited the responsibility from an administrator who has left the hospital. Until recently, he managed the project with the assistance of a financial accountant. With the hiring of two new administrators of outpatient and inpatient clinics, he will have some additional help.

Partly because of understaffing, the University of Health Sciences has opposed the state's quarterly reporting requirements and contends that the state requires an unreasonable amount of data. It further believes that capitated health plans should not have to submit pseudo claims and, in particular, should not have to resubmit claims that are "denied."

Although the PHP is currently breaking even, it may be financially precarious. The plan estimates that inpatient days per 1,000 enrollees have averaged 363, compared to a target of 800. However, out-of-plan use by enrollees has been extensive and the inpatient days paid for by the plan could increase in the future. The University of Health Sciences has been incurring \$5,000 per month in claims from other institutions. However, the hospital is only paying other hospitals for emergency room visits and specialty care that is not provided in its own clinics. These hospital claims constitute only 20

percent of the incoming claims. (The remainder of claims consist of primary care and hospital stays in other institutions). An emergency room physician is reviewing the claims from other providers to assure that services were medically necessary.

3. Wayne Miner Health Center

Wayne Miner Health Center is a community health center supported by a Public Health Service grant. It has been in operation since 1968 and is located adjacent to a number of public housing complexes in north central Kansas City. The Center provides primary care on a sliding fee basis to approximately 11,000 persons. It offers primary care services, including general medical care, home health care services, blood pressure screening, and services for adolescents. With the help of translators, the Center provides health care to Vietnamese and Laotian refugees.

As of August 1985 the Center had enrolled 1,884 AFDC recipients in its PHP, representing 8 percent of total MHCP enrollment. The center had hoped to attract 10 percent of the MHCP population and intends to undertake a marketing effort to expand enrollment.

In preparation for the demonstration, Wayne Miner negotiated contracts with two referral hospitals, Truman Medical Center and Children's Mercy Hospital. These hospitals were selected because of long-standing referral relationships. Wayne Miner pays the Medicaid per diem rate to each hospital. The medical director feels the Wayne Miner plan could achieve greater savings if it could refer to less expensive hospitals, but private hospitals would not agree to participate in the demonstration.

Wayne Miner is conscientious about controlling utilization under the demonstration. Prior to start-up, the medical director conducted several training sessions for the center's nine full-time primary care physicians.

New procedures were instituted for monitoring medical necessity and for overseeing hospitalizations. At present, one physician is always on 24-hour call. This physician must authorize services rendered by contract hospitals after Center hours. He or she visits hospitalized patients every morning before reporting to the Center. In addition, the medical director reviews all requests for hospital admissions according to medical criteria developed specifically for the demonstration. Claims from referral specialists are reviewed for medical necessity by a multi-disciplinary committee.

Like the other PHPs, Wayne Miner is experiencing considerable out-of-plan use and it will not pay for unauthorized care. This position has seriously penalized several providers. Wayne Miner officials were unable to estimate the total dollar amount of denied claims but stated that the Center is keeping a tally of unpaid bills. These bills may be paid eventually, but the PHP wants to impress upon providers that they must "play by the rules." In the meantime, Wayne Miner plans to send a mailing to enrollees every few months reminding them to telephone the Center before seeking care elsewhere.

Thus far, Wayne Miner has easily met its utilization targets. The plan estimates it is averaging 200-300 hospital days per 1,000 enrollees. The Center suspects that strong medical review has helped reduce utilization, but the staff acknowledge that considerable nonreimbursed out-of-plan use occurred in the early months of the program. Wayne Miner has not yet encountered any high cost cases. Only one patient, who was sick when she enrolled, has reached \$15,000 in medical expenses. Wayne Miner is concerned that it may encounter more such cases because of the nature of its enrollment -- typically older women and high risk adolescents.

Although utilization has been favorable, Wayne Miner has incurred losses due to uncompensated staffing costs. The Center hired 12 additional staff who were partially dedicated to the demonstration project. Because of delays in program start-up, Wayne Miner incurred staffing costs for several months before capitation revenues began to flow.

4. Swope Parkway Comprehensive Mental Health Center

Swope Parkway is a neighborhood health center that also receive support through a Public Health Service grant. Located in the middle of Kansas City, the Center provides primary care and mental health services to more than 31,000 patients, of whom about half are Medicaid recipients. It charges all patients on a sliding scale. In the past year, ambulatory visits have declined considerably, forcing the Center to freeze staff salaries. Efforts are underway to increase the patient base. A marketing campaign, involving billboard advertising and direct mailings, will be targeted to private pay patients who live in surrounding neighborhoods.

As of August 1985, Swope Parkway PHP enrollment was 2,943, or almost 13 percent of the AFDC population. Swope Parkway would like to expand its enrollment and would be interested in marketing to AFDC recipients directly. However, for financial reasons, the Center has not yet availed itself of the marketing opportunities allowed under the demonstration.

Before the MHCP became operational, Swope Parkway conducted extensive planning to assure that necessary administrative procedures were in place to manage risk. Although it has relationships with other hospitals in town, the Center decided to contract with Truman Medical Center and Children's Mercy Hospital, both of which accepted Medicaid per diem reimbursement rates. These institutions were chosen because they had accepted referrals in the past and staff had good working relationships.

As early as April 1982 (soon after the project was announced by the state), the Center began to work with its staff physicians to prepare them for new responsibilities under a capitation program. The Chief of Clinical Services has conducted numerous orientation sessions for the Center's 23 staff physicians. At present, physicians in the various departments (e.g., internal medicine, obstetrics, and pediatrics) precertify admissions, monitor hospitalized patients, and work with the residents at contract hospitals to

plan discharges. Physicians are responsible for utilization review. They also rotate "call duty." Physicians on call must be available on a 24-hour basis to approve after-hours care rendered at contract facilities. A concerted effort is being made to discharge patients earlier and to use home health care services, if appropriate. For example, the Chief of Clinical Services has met with staff obstetricians to discuss reducing lengths of stay for uncomplicated obstetrical cases from three to two days. Now, an effort is underway to reduce two day stays to one. In addition, the Center would like to have a utilization review coordinator to "triage" patients and assist physicians in concurrent review of hospital stays, but the funds are not available.

Recently, Swope Parkway hired a patient care coordinator who devotes half time to the PHP. She ensures that enrollees understand the procedures for using the prepaid plan and encourages all enrollees to call Swope Parkway before going to the emergency room for care. As a result of these efforts, 80 percent of PHP enrollees reportedly call the Center before seeking health care.

Swope Parkway believes that patient orientation efforts have significantly reduced out-of-plan use. As a result, the Center was able to avoid conflicts with other providers over claims for non-emergency care. Unlike its sister health center plan, Swope Parkway has agreed to pay most of the claims for out-of-plan care. In FY 1984, Swope Parkway asserts that only 15 days of out-of-plan use were denied.

Overall, Swope Parkway is pleased with its financial performance to date. Thanks to patient orientation efforts and strict utilization review, the plan estimates it is averaging only 316 hospital days per 1,000 enrollees.

In the future, Swope Parkway would like to expand the PHP to small employers whose employees live in the vicinity and to other parts of the

state. Swope Parkway also believes that the state should reward plans that are performing well by limiting the number of participating plans and channeling the patients to them. They believe that only by increasing market share can they achieve economies of scale.

5. Prevention Plus

This plan is a subsidiary of the Blue Cross-Blue Shield Total Health Care IPA. Established in 1982, Total Health Care now has 80,000 members. Over 2,000 physicians in the Kansas City metropolitan area participate in the plan. It had not previously contracted with Medicaid. Blue Cross originally decided to participate in the MHCP as a courtesy to its physicians, who saw an opportunity to benefit from Medicaid rates. At present, 53 physicians are participating in Prevention Plus. All are experienced with capitation due to their affiliation with Total Health Care. Most have inner-city practices with large AFDC caseloads.

Operating procedures for Prevention Plus are the same as for Total Health Care. For example, participating physicians are subject to the same utilization review programs (i.e., pre-admission certification and concurrent review) that are used under Total Health Care. Enrollees have access to 14 major hospitals in Jackson County at which participating physicians have admitting privileges. With these hospitals, Blue Cross has negotiated per diem rates that are within 20 percent of Medicaid per diem rates.

Reimbursement arrangements under Prevention Plus are modeled on Total Health Care and work as follows: Blue Cross deducts a portion of the state capitation payment for administrative costs (approximately 15 percent) as well as the capitation fees for laboratory and psychiatric care. Participating primary care physicians receive the remainder of the capitation amount, less an allowance for a referral fund. The referral fund is used for fee-for-

service payments to hospitals, physician specialists, and other miscellaneous services. At the end of the year, if the referral fund has a surplus, the primary care physicians share in half of it on a prorated amount based on the number of recipients who use a particular physician. If the fund has a deficit, it is shared up to a preestablished maximum.

Blue Cross' decision to participate in the MHCP was predicated on enrolling at least 4,500 AFDC recipients in the first year of the demonstration. Actual enrollment has been on target -- as of August 1985, Prevention Plus had enrolled 4,228 AFDC recipients, almost 19 percent of the population. Ideally, Prevention Plus would like to attract more patients but is moving slowly while still learning about this population.

To comply with MHCP procedures and reporting requirements, Prevention Plus has hired additional staff. A customer service representative devotes half time to answering questions for Prevention Plus enrollees. In addition, two full-time clerical personnel were hired to prepare pseudo claims and quarterly cost and utilization reports. Finally, one full-time nurse coordinator handles patient care and utilization problems.

Despite these additional administrative costs, Blue Cross has done well financially. Representatives declined to specify utilization rates but indicated that hospital days per thousand enrollees were well below state targets. Their success is due, in part, to the fact that primary care physicians have strong financial incentives to control referrals and admissions. Further, Prevention Plus routinely denies unauthorized claims for out-of-plan use.

However, Blue Cross representatives feel that Prevention Plus may not be as financially secure as it appears on the surface. The plan had one client

that exceeded the \$20,000 stop loss provision; a severely ill infant who may be a candidate for a liver transplant. Under this stop-loss provision, after the plan has incurred Medicaid equivalent costs of \$20,000 for an enrollee each year, the state makes fee-for-service payments to the plan based on Medicaid allowed amounts. Prevention Plus negotiated rates with providers that are higher than Medicaid-allowed amounts. As a result, the stop-loss provision may be triggered at a higher threshold than \$20,000.

Despite these problems, Prevention Plus is optimistic about the program and would like to increase its enrollment in the future. Preliminary feedback from enrollees is favorable, suggesting that there may be opportunities for expansion. However, future marketing plans have not yet been developed. Prevention Plus' main objective is to satisfy participating physicians. As a result, they will work with the state to assure that the capitation rates continue to be adequate.

6. Physician Sponsors

As of August 1985, 3,593 AFDC recipients (15.7 percent of the population) had enrolled with fifty-four physician sponsors. Most of these sponsors have historically participated in the Medicaid program and are presumably well-known among the patients. Over half are general or family practitioners, and most of the remainder are pediatricians and obstetrician-gynecologists. A few surgeons and psychiatrists also participate. Two methods of payment are available to physician sponsors. First, they are paid \$1.50 per patient per month to case enrolled patients, which entails responsibility for managing all aspects of enrolled patients' care. Management responsibilities include being available on a twenty-four hour basis to provide case management, making written referrals to specialists, following up on the specialty care enrolled patients receive, and overseeing all hospitalizations. Second, physician sponsors are paid fee-for-service for providing the full spectrum of primary care for their patients, including screening and diagnostic tests required by the Medicaid EPSDT program.

In the past year, the state Prepaid Health Unit has worked extensively with participating physician sponsors to acquaint them with their new responsibilities, including billing procedures. To assist in this effort, the state has retained Dr. Starks Williams, a pediatrician from Kansas City, who serves as medical consultant to the PSP. In addition, the state conducted a workshop on filling out referral forms for physician sponsors' staff during the summer of 1984.

For most of the participants, the responsibilities required by the PHP represent a change from past practices under the Medicaid program. Several physician sponsors who were interviewed for this study suggested that participating doctors are having difficulty functioning effectively as case managers. Evidently, a number of Medicaid patients do not yet understand the program and continue to seek care from hospital emergency rooms and outpatient clinics. These institutions will call the physician sponsor to request a referral form after the care has been rendered. Usually, the physician sponsor complies because he does not want to cause a reimbursement problem for the hospital. One physician said the \$1.50 monthly case management fee barely covers the cost of typing and mailing referral forms.

Physician sponsors are now reminding their patients to telephone before they self-refer to other health care providers. They indicate that many of their regular patients are conscientious about complying. However, the sponsors find it difficult to educate patients they see infrequently. Further, some enrolled patients have never before presented for treatment. As one physician said, "If I get a call from Children's Mercy about someone I have never seen before, I tell them to treat the patient, because I don't know what's going on." Consequently, a few physician sponsors feel the state should conduct frequent educational sessions with AFDC enrollees to ensure that they use the system properly.

Although the majority of Medicaid outpatient specialty care in Jackson County is provided by Children's Mercy Hospital and Truman Medical Center, a few independently practicing specialists also accept Medicaid patients. These practitioners have been concerned that the PSP would disrupt their patient referral relationships. In response, the state distributed to all physician sponsors a list of specialists who are willing to accept Medicaid referrals. This has mollified many of the specialists, but a few continue to oppose the program. One dermatologist, in particular, reports that he has experienced a 90 percent decline in his Medicaid patient load, representing \$10,000 in lost income this year. He complains that primary care physicians prefer to handle dermatological problems rather than refer.

C. PROBLEMS PHPs AND PSPs HAVE ENCOUNTERED

Although problems have arisen, most participants feel they have been resolved satisfactorily. Some concern was expressed that high staff turnover in the state Prepaid Health Care Unit has caused some delays in dealing with problems. Uniformly, however, participants agree that the state has made an effort to understand their problems and to help resolve them. This section describes problems that PHPs and physician sponsors encountered during start-up, specifically:

- **Out-of-Plan Use:** A significant number of AFDC recipients do not yet understand the lock-in requirements and continue to self-refer for care. To date, it appears that the majority of out-of-plan use has been for pediatric care provided by Children's Mercy Hospital. Children's Mercy Hospital has taken the position that legally, it must treat all patients who seek care. Not only has the hospital provided emergency care, but the medical staff have scheduled follow-up visits without attempting to obtain appropriate authorization. Several PHPs and other providers have refused to pay unauthorized claims from Children's Mercy Hospital. Denials for nonemergency care have mounted, and Children's has incurred a significant deficit. More recently, Children's Mercy Hospital has changed its position and is actively working with the state to find a solution to the out-of-plan use problem at their facility. Children's staff have now been instructed to obtain approval from the primary plan or physician sponsor before rendering care. They have also established procedures to document contacts with plans and the physician sponsors.

- Patient Education: The out-of-plan use problem has led both providers and the state to conclude that patient education is needed. The PHPs and physician sponsors feel they should share the responsibility for patient education with the state. They have requested that the state send frequent mailings to recipients, reminding them of their obligations.
- State Random Assignment Process: Six percent of AFDC recipients who failed to respond to letters inviting them to attend a Choice presentation were randomly assigned to a PHP. PHPs asked the state to consider another approach, such as assignment to the "primary provider" (i.e., the one the recipient uses most often). To test the feasibility of this approach, the state analyzed the utilization history of seven randomly assigned recipients. These recipients had received care from multiple providers and it was not possible to discern which was primary. Consequently, the state decided to continue its random assignment policy.
- Enrollment and Marketing: PHPs are concerned that the Choice enrollment process did not allow them to market their plans to their best advantage. Further, although the presentation was supposed to be impartial, some plans felt that the material contained hidden biases. The state has welcomed suggestions from plans and is continually improving the Choice presentation.
- Reporting: PHPs have complained that preparation of Medicaid pseudo claims and quarterly cost and utilization reports is burdensome because these reports are not yet computerized. A few plans object to devoting staff to reporting. In addition, several PHPs have objected to delays in receiving instructions for submission of pseudo claims from the state.
- Future Plans: Most of the PHPs feel that they have made an extensive investment in the MHCP demonstration. They have invested in marketing materials, management information systems, and utilization review procedures. Most would like a chance to expand and begin to compete with one another for patients. They are concerned that the demonstration will end before they have had a chance to prove themselves. Like the state, the PHPs would like the program to become a permanent part of Missouri Medicaid.

CHAPTER FIVE
CONSUMER PERSPECTIVE

A. INTRODUCTION

The first year of MHCP operations has been a period of adjustment for AFDC recipients, who no longer have free choice of providers, and, instead, must seek all of their health care from a single source. The state attempted to minimize disruption to consumers by assuring that the major Medicaid providers were included in the demonstration. Predictably, enrollment patterns suggest that AFDC recipients chose the providers they ordinarily use.

The "lock-in" nature of the program was intended to improve efficiency in service delivery and continuity of care for recipients. Many AFDC recipients did not understand the new program, however, and went out-of-plan during the first year. Reports suggest that these out-of-plan users were given treatment by providers who then billed the health plan or obtained a referral form from a physician sponsor. Thus, the health of consumers does not appear to be adversely affected. The state has taken action, however, to contact out-of-plan users and encourage them to comply with the program.

This chapter covers the community awareness of MHCP and the potential effect of the demonstration on consumers.

B. COMMUNITY AWARENESS

During the planning phase, the state held public meetings in Kansas City to inform the community of the demonstration. These efforts, combined with a mailing to all AFDC recipients from the County Department of Social Services and outreach by the Welfare Rights Organization, resulted in consumer

awareness of the demonstration. The Jackson County Choice workers report that many recipients were aware of the project when they came in for the enrollment presentation.

On March 1, 1985, a local Kansas City television station aired a news clip describing the MHCP. The reporter interviewed a Swope Parkway client and Ms. Pat Pacheco, Choice Supervisor, in the county Department of Social Services office. The report was favorable, and the state feels it has helped improve community awareness.

C. EFFECT ON CONSUMERS

Although a few AFDC recipients did not understand the program during the first few months of operation, the state and participating providers have taken steps to educate them. This section deals with the out-of-plan use problem, continuity of care for chronically ill recipients, and patient satisfaction.

The problem of out-of-plan use is believed to have been widespread during the first year, but the state has not been able to quantify its extensiveness. Several prepaid plans and physician sponsors feel that it is difficult to change long-standing utilization patterns in a single year. Historically, AFDC mothers were encouraged by neighborhood health centers and private physicians to use Truman Medical Center and Children's Mercy Hospital emergency rooms for after hours care. Slowly, these patterns are changing as a result of education by the county Choice workers, letters from the Welfare Rights Organization and the state urging recipients to comply with the program, and orientation sessions conducted by prepaid plans and physician sponsors.

Several providers, notably Children's Mercy Hospital, are concerned that the MHCP may have interrupted ongoing treatment programs for some patients

with chronic illness. The MHCP procedures require PHPs and physician sponsors to provide all primary care to enrolled patients. Consequently, a child with a specialized medical problem, who formerly was treated at Children's Mercy Hospital, would not be able to continue unless the plan or physician sponsor agreed to make a referral. Children's is now working with the PHPs and physician sponsors to develop a routine referral procedure that will maintain continuity of care.

Further, to minimize disruption of an ongoing treatment plan, PHPs have agreed to transfer patients back to their original provider. For example, if Truman Medical Center is treating a diabetic patient in its outpatient clinic, and she is assigned to another PHP, the PHP and Truman may agree to transfer the patient to Truman permanently. The state must approve the transfer if it occurs after the patient has been enrolled for 60 days.

Whether patients are satisfied with the new program is difficult to determine at this time, although preliminary indications are favorable. Results of the patient satisfaction questionnaire, which is administered by the state Prepaid Health Unit, suggest that the majority of patients are satisfied with the care being provided by physician sponsors and PHPs. Further, the quality assurance unit of the state indicates that few complaints have been filed. Patients requesting transfers did so primarily because their physician or plan was not located conveniently, not because they were dissatisfied with the care. Thus far, no formal grievances against health plans have been filed. Finally, representatives of the Welfare Rights Organization stated that they have received very few comments or complaints from their constituents. They believe the absence of comment indicates that AFDC recipients are receiving the care they need under the program.

CHAPTER SIX

CONCLUSIONS

A. INTRODUCTION

The first year of MHCP operations was a shake-down period, during which the state made adjustments to its administrative procedures, enrollees learned to obtain health care services from a single plan or provider, and participating providers developed their own operating style. This chapter discusses some of the issues that arose during the first year of MHCP operations. These issues may be relevant to other states that are considering similar programs. They include:

- Unanticipated administrative problems which arose during the first year of MHCP operations.
- The need for ongoing education of recipients about the "lock-in" nature of the program.
- How to set plan-specific rates for PHPs in the future.
- Changes in practice patterns and relationships among PHPs and physician sponsors to comply with the demonstration.
- The emergence of competition among participating PHPs.
- PHP marketing activities.
- Potential PSP savings.
- The impact of the MHCP on public institutions.

B. UNANTICIPATED ADMINISTRATIVE PROBLEMS

The State of Missouri conducted a 17-month planning effort before implementing the MHCP. Most of the planning focused on negotiating contracts

with prepaid plans and physician sponsors, designing the enrollment process, and ensuring that proper administrative and management procedures would be in place when the MHCP became operational. However, the demonstration began enrolling patients before all of the necessary procedures had been developed. The state reasoned that these procedures could be finalized while the MHCP was operating. In retrospect, the state may not have fully anticipated the level of effort necessary to put these systems in place and to handle the inevitable problems which arise during program start-up. Fortunately, the Prepaid Health Unit had assembled an experienced team of professionals, who were able to devote full-time to program operations. In addition, the Unit was able to draw upon other resources within the Medicaid division, including the MMIS and SURS staff, for help in carrying out the project.

Some of the unanticipated administrative problems (which are documented in greater detail in Chapter Three) included:

- lengthy period of testing and retesting the MMIS subsystem,
- difficulties enrolling certain groups, particularly newborns,
- out-of-plan use due to random assignment of recipients who do not make a choice,
- delays in development of quality assurance procedures (due to staff turnover), and
- lack of uniformity in plan financial reporting.

Despite these problems, thanks to the conscientious efforts of the staff of the Prepaid Health Unit, the MHCP demonstration is now operating relatively smoothly.

C. THE NEED FOR ONGOING EDUCATION OF RECIPIENTS AND PROVIDERS

From the outset, the state recognized that recipient education and provider cooperation would be key to smooth operation of the MHCP. With respect to recipient education, the Choice process was intentionally designed to assure that recipients would receive objective and accurate

information. Based on research findings from other prepaid health plan demonstrations, the state believed that AFDC recipients would be more willing to participate if given special counseling before making their selection, and would be better informed and would be less likely to switch providers. However, a significant number of recipients who attend the Choice presentation, do not understand the "lock-in" nature of the MHCP and are apt to go out-of-plan for care.

Unfortunately, the out-of-plan use problem was compounded the first year by providers who did not comply with the program. A number of providers delivered care without seeking authorization from the patients' assigned PHP or physician sponsor. As a result, the patients received care but did not learn how to use the new system properly. Further, several PHPs have denied claims for out-of-plan care, causing financial problems for some providers. The state is working with several providers who have not complied with the program.

In addition, to stem out-of-plan use, participating providers have asked the state Prepaid Health Unit to conduct patient education more frequently. If necessary, they would like the state to penalize recipients who do not comply with the program. In response, the state has agreed to send letters remonstrating recipients who frequently go out-of-plan for care. In addition, a few PHPs have decided to conduct their own orientation sessions.

Over the next year, a key issue is whether the state or MHCP providers will take primary responsibility for patient education. How will denied claims for out-of-plan use be resolved? At present, the state is not getting involved and is referring providers to the PHPs.

D. HOW TO SET PLAN-SPECIFIC RATES FOR PHPs IN THE FUTURE

In the next few years, the state hopes to move to plan-specific rates which reflect the experience and case mix of each plan. The demonstration

protocol calls for costs to be calculated by age and sex categories by plan. Plan quarterly cost and utilization data will be used to compute fee-for-service equivalents.

This rate setting approach raises both technical and equity issues. First, by relying upon each plan's experience, the state loses the average AFDC fee-for-service base. Second, the state may have difficulty estimating each plan's experience, since it is not accustomed to costing by beneficiary group, and the pseudo claims may not afford accuracy for ratesetting. Third, if the rate is tied to plan-specific cost and utilization, it must ensure that it does not reward inefficient plans and penalize efficient ones. Perhaps a reconsideration of this approach is in order.

E. CHANGES IN PRACTICE PATTERNS AND RELATIONSHIPS AMONG PHPS AND PHYSICIAN SPONSORS

The MHCP has prompted participating PHPs and PSPs to alter their practice patterns and relationships to other Medicaid providers in the community. A range of responses has been observed among each provider group. Since Prevention Plus physicians have previous experience with prepayment, few changes have been necessary. For the neighborhood health centers, however, the changes in practice and relationships have been dramatic. They have had to train their physicians to assume responsibility for after-hours care and for all hospitalizations. In addition, the centers have established utilization review procedures to control hospital stays. Fortunately, the health centers have amicable relations with contract hospitals, which has reduced the potential for conflict. However, some disputes have arisen over claims for out-of-plan use. Wayne Miner has denied most of these claims; it "plays by the book." Swope Parkway has paid most of these claims, but works with hospitals to prevent recurrences. The centers believe this approach is necessary because they do not have cash reserves and cannot, therefore, incur deficits.

In contrast, the hospital-based PHPs have made fewer changes in response to the MHCP. Both Truman Medical Center and the University of Health Sciences have limited the resources devoted to the program, and other activities, e.g., medical education and care for the poor, have tended to take precedence over the PHP. The hospitals have concentrated on meeting procedural requirements but have not changed the patient management process.

Finally, it appears that some physician sponsors have not yet been able to "perform case management" for their enrolled patients in the manner required by the PSP. Part of the problem is that some of the patients may not be cooperative and the program does not contain incentives to change behavior. Further, PSPs find it more difficult to control of patients seen infrequently or who have not yet come in for an office visit. They feel compelled to approve care in a specialty outpatient clinic or an emergency room for patients they have never treated before. Further, they are reluctant to jeopardize relationships with referral specialists and are likely to approve retroactive requests for referral forms. A key issue is whether, as the program progresses, physician sponsors will be able to manage their enrolled patients effectively.

F. THE EMERGENCE OF COMPETITION AMONG PHPs

When the first case study of the MHCP was written, Medicaid providers were concentrating on making the transition to PHPs and competition had not yet occurred. Most plans were hoping to preserve (and not necessarily increase) their AFDC market share. They were not competing on the basis of benefits; none were offering dental or transportation benefits. Rather, they were hoping that reputation and location would be effective marketing tools. Early enrollment data suggested that PHPs were, for the most part, able to maintain their historical market share. Recipients tended to choose plans that were convenient to use and that they had used in the past.

For several reasons, PHPs have begun to show a heightened interest in competition. Although it is possible that they overestimated their historical AFDC patient loads, a few PHPs have been disappointed in their enrollments. Other PHPs are concerned about the costs of utilization review and other aspects of a PHP. They would like to expand enrollment in order to achieve economies of scale.

It is too early to say what form competitive behavior will take. A few plans would like the state to limit the number of participating plans and, in effect, "reward" financially successful plans by giving them more patients. Several PHPs fear that Prevention Plus will be a formidable competitor and could gain a high proportion of the market, thus excluding institutions that have traditionally served the poor. Over the next year, a new form of competition among plans may emerge. PHPs may embark on aggressive marketing campaigns. Market share may shift as traditional Medicaid providers attempt to compete against Prevention Plus.

G. PHP MARKETING ACTIVITIES

As competition intensifies over the next year, the PHPs may mount a marketing campaign that is independent of the county Choice presentation. A key question is how aggressively will they market? Will they expand benefits to attract enrollees? What type of benefits will be made attractive to this low income population? Will patients be willing to make a switch? Will the state develop procedures that make it easy for patients to switch?

H. POTENTIAL PSP SAVINGS

By paying \$1.50 per enrollee per month, the PSP rewards primary care physicians for changing their management of Medicaid patients. It is uncertain whether this program, which does not entail financial risk for participating physicians, can be effective in controlling Medicaid

expenditures. When a full year of claims data become available, the state will analyze whether the PSP actually led physician sponsors to forge new relationships with specialists and hospitals. The key issue is whether hospitalizations and referral utilization has declined among the enrolled population in the absence of physicians bearing some risk.

I. THE IMPACT OF THE MHCP ON PUBLIC INSTITUTIONS

As the Jackson County health care marketplace becomes more competitive, public institutions may not be able to compete successfully. Further, some of the participating hospitals and neighborhood health centers believe the MHCP may contribute further to their financial instability, particularly if capitation rates represent a reduction in Medicaid revenues. They are concerned that Medicaid may not contribute its fair share to the support of medical education and indigent care. An open issue is whether the deficits incurred by these institutions reflects inefficient behavior or inadequate reimbursement for the additional responsibilities they bear. If, in fact, the MHCP further inhibits their ability to compete, a number of additional questions arise. Will the state or county assume responsibility by increasing public expenditures to replace lost revenues? Or will the MHCP contribute to an overall reduction in revenues, making these institutions even less able to carry out their missions?

APPENDIX A

LIST OF INTERVIEWEES

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Evaluation of Medicaid Competition Demonstrations

Volume VII

The New Jersey Medicaid Personal Physician Plan

by

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PREFACE

In September 1983, the Office of Research and Demonstrations in the Health Care Financing Administration awarded a contract to a consortium, headed by the Research Triangle Institute (RTI) to evaluate Medicaid competition demonstrations in California, Missouri, New Jersey, Minnesota, New York, and Florida. The evaluation is designed to determine which different organizational structures and competition strategies result in cost savings. The evaluation is also to determine if these goals can be realized without jeopardizing quality of care and patient and provider satisfaction or imposing unreasonable administrative burdens. Both quantitative and qualitative analyses will be used in the evaluation. Case studies exploring implementation and operational issues in each demonstration site are an important part of the evaluation. Four sets of case studies will be performed over four years to document changes in the design, operations, and outcomes of the demonstration. These case studies are the responsibility of the American Enterprise Institute for Public Policy Research (AEI) and Lewin and Associates.

This report is the second case study of the New Jersey Medicaid Personal Physician Plan (MP Plan). The first case study was prepared during the period when the demonstration was being pilot-tested in three rural and suburban New Jersey counties and introduced into five

more populous counties. It examined the background for the development of the MP Plan and looked at some of the early implementation issues.

The site visits for this second case study were conducted in May and July 1985. During this time, the second phase of implementation was being completed and the New Jersey Medicaid officials were preparing to introduce the demonstration into the remaining counties in the state. This report focuses on major changes in the design of the demonstration and ongoing implementation issues. Future case studies will continue to report on the effects of the demonstration on utilization patterns, cost, and quality of care.

The author is grateful to the many people who gave their time to be interviewed for this study. I would particularly like to thank S. Eugene Yuliano, M.D., Project Director for the MP Plan, Jill Simone, M.D., Assistant Director of the MP Plan, and their staff in the Office of Prepaid Health Care; Thomas Russo, Director of DMAHS; and George Logusch, consultant to the MP Plan. Special thanks to my colleagues, Sean Sullivan and Rosemary Gibson Kern, who also conducted the site visits and provided assistance and support in the preparation of this report. I would also like to express appreciation to Jack A. Meyer, Director of the American Enterprise Institute Center for Health Policy Research, John E. Paul of the Research Triangle Institute, Deborah A. Freund of the University of North Carolina, and Lou Rossiter of the University of Virginia for their valuable insights and comments.

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CHAPTER ONE

OVERVIEW OF THE DEMONSTRATION

A. General Description of the MP Plan

The Medicaid Personal Physician Plan (MP Plan) is a voluntary Medicaid program that is being offered to New Jersey Medicaid eligibles as an alternative to the regular fee-for-service Medicaid program. It is based on a capitated, case management model, incorporating two separate capitation systems -- one for primary care and referral services, and one for inpatient hospital care. The model includes the use of brokers to act as administrative intermediaries between the MP Plan staff and the county welfare agencies, physicians and Medicaid eligibles enrolled in the Plan.

The Plan was originally to be implemented in four phases over the three year demonstration period, with each phase bringing in a new group of counties until the Plan was eventually operating on a state-wide basis. The implementation process was scaled down to three phases however, when three counties (Essex, Passaic, and Union) that were originally scheduled to enter the demonstration during Phase III instead were brought in during Phase II.

Each phase was designed to allow the Plan staff to test certain features of the Plan. Phase I began in July 1983 in three rural and suburban counties in northwestern New Jersey -- Morris, Sussex and Warren. This phase enabled the staff to evaluate and refine the Plan's administrative systems prior to enrolling large numbers of

beneficiaries in the more populous regions of the state. Phase II of the program introduced the inpatient capitation component of the Plan. It has been operating since August 1984 in five counties in central and southern New Jersey -- Atlantic, Burlington, Camden, Mercer and Middlesex -- where the majority of the state's Medicaid population is concentrated. (The program was subsequently introduced in Essex, Passaic, and Union counties.) The final phase was scheduled to begin in July 1985 in the remaining counties, thus testing the ability of the MP Plan to operate on a statewide basis.

As of February 1986, however, the actual starting date for Phase III remains uncertain. In the fall of 1985 HCFA delayed the expansion of the program until Plan officials were able to demonstrate that the Plan's management information systems were operating and producing the necessary reports. While the state, after considerable delay, has now developed many components of this management information system, expansion into the remaining counties is still being held up, and is contingent upon HCFA's approval of the state's 1915(b) waiver application. (A 1915(b) waiver will be necessary for the Plan to continue operations after June 30, 1986 when the demonstration waivers expire.) In fact, HCFA has requested that, as of January 1, 1986, New Jersey cease enrolling any additional Medicaid eligibles in the Plan because the state cannot guarantee these individuals six months of eligibility under the program (as stipulated in the protocol for the demonstration).

New Jersey's Medicaid program is administered by the Division of Medical Assistance and Health Services (DMAHS) in the State Department of Human Services. The MP Plan is administered by the Office of

Prepaid Health Care (OPHC), a subdivision of DMAHS. The OPHC staff consists of six persons, including physicians involved with provider relations and medical and administrative matters, staff responsible for coordinating the information systems and claims processing specialists, and other staff members who act as liaisons between the Medicaid headquarters, the Department of Human Services, county welfare agencies, and DMAHS field offices. DMAHS also contracts with consultants with expertise in marketing, administrative services, and the state's DRG-based hospital payment system.

All persons who are eligible for Medicaid may enroll in the MP Plan, except those who are institutionalized. All Medicaid benefits are provided under the Plan, with the exception of long-term care, medical day care, transportation, prosthetics and orthotics, and dental services. (See Appendix I for a complete list of MP Plan benefits.)

The demonstration was developed to address the following problems plaguing the New Jersey Medicaid program:

- o decreasing physician participation in Medicaid (due to low reimbursement rates), with a corresponding reduction in access to health care for Medicaid recipients;
- o increasing Medicaid costs, due in part to inappropriate utilization of health care services as described below;
- o inappropriate utilization of health care services, including doctor-shopping, self-referrals, and use of the emergency room for routine care, resulting in lack of continuity of care and higher program costs.

A PSRO study commissioned by DMAHS and completed in February 1985 found that an average of 64 percent of emergency room visits were for non-emergency care. The average cost of an emergency room visit in New Jersey is \$60, whereas a visit to a primary care physician costs \$7 under the Medicaid program. DMAHS estimates that inappropriate

utilization of the emergency room cost the Medicaid program \$38 million in 1982.

The MP Plan was designed to benefit both Medicaid providers and Medicaid recipients. DMAHS officials hope that the case management model will improve the quality and continuity of care that is available to Medicaid recipients and encourage their use of lower cost, appropriate primary care providers. At the same time, the prepaid plan offers providers the opportunity for higher levels of payment than they receive under the fee-for-service Medicaid program, a better cash flow, and less paperwork. DMAHS hopes that these incentives will attract more physicians to the Medicaid program and encourage currently participating physicians to increase their Medicaid patient loads.

The overall financial goal of the MP Plan is to provide care for the Plan enrollees at 95 percent of the costs incurred under the fee-for-service portion of the Medicaid program.

B. Status of the Demonstration

Current MP Plan enrollment is well below the projected figure of 40,000 enrollees for Phase II. The average number of enrollees per month in the MP Plan has been approximately 8,400 since January 1985, or approximately 1.8 percent of the total number of Medicaid eligibles in the state. DMAHS had hoped to enroll 100,000 Medicaid eligibles (20 percent of New Jersey's total Medicaid eligible population) in the program by the end of the demonstration period; however, during the summer of 1985 that enrollment target was adjusted. The Plan staff projected that 40,000 eligibles, (approximately 7.7 percent of the

total Medicaid eligible population) would have been enrolled by June 1986 had Phase III been implemented on schedule in July 1985. It is unclear at this time how many beneficiaries might eventually be enrolled in the Plan, given that further expansion of the Plan has been delayed pending HCFA's approval of the 1915(b) waiver application.

The majority (96 percent) of the program's enrollees are AFDC recipients (see Table I). Enrollment is concentrated in Atlantic, Camden and Essex counties. These counties account for 81.5 percent of the total MP Plan enrollment. They encompass the major urban areas of the state with large Medicaid populations. Table II gives a breakdown of the total MP Plan enrollment by county as of June 1985.

There are currently 219 physicians participating in the Plan as case managers, or 2.4 percent of the physicians in the state who see Medicaid patients. Table II shows the distribution of participating physicians on a county basis. The Physician Case Managers (PCMs) can be characterized by specialty and practice type as follows:

<u>Specialty</u>	<u># of PCMS</u>	<u>Practice Type</u>	<u># of PCMS</u>
General/Family Practice	82	Solo	98
Pediatrics	77	Partner	26
Internal Medicine	47	Group	95
Obstetrics/Gynecology	12		
Other	1		

According to state officials, the small number of obstetricians and gynecologists participating in the MP Plan is a reflection of these physicians' low rate of participation in the Medicaid program generally. The MP Plan administrators attribute this group's low rate of participation to the recent increase in the number of malpractice suits

TABLE I

MP PLAN ENROLLMENT BY ELIGIBILITY CATEGORY

<u>ELIGIBILITY CATEGORY</u>	<u>AVERAGE MONTHLY ENROLLMENT</u> *	<u>PERCENT OF TOTAL AVERAGE MONTHLY ENROLLMENT</u>
Old Age Assistance Program (OAA)	67	1%
Disability Assistance (DA)	248	3%
Aid to Families with Dependent Children (AFDC)	8043	96%
Assistance for the Blind (AB)	6	1%
Division of Youth and Family Services (DYFS)	10	1%
Medical Assistance for the Aged (MAA)	1	1%
Cuban Refugee Program (CR)	0	0%
<u>TOTAL</u>	<u>8375</u>	

* These numbers reflect the average monthly enrollment for January 1985 through June 1985.

Source: Office of Prepaid Health Care, Division of Medical Assistance and Human Services, New Jersey Department of Human Services.

TABLE II

MP PLAN ENROLLMENT BY COUNTY

COUNTY	MP PLAN RECIPIENTS 6/1/86	MP PERCENT TOTAL	PERCENT TOTAL MEDICAID ELIGIBLES	NUMBER OF PARTICIPATING PCMs
Atlantic	2305	24.2	14.0	34
Bergen *	2	0.0	0.0	0
Burlington	369	3.9	2.0	31
Camden	1615	17.0	3.0	33
Cape May *	2	0.0	0.0	0
Cumberland *	2	0.0	0.0	0
Essex	3835	40.3	3.0	35
Gloucester *	4	0.1	0.0	0
Hudson *	7	0.1	0.0	0
Hunterdon *	2	0.0	0.0	0
Mercer	12	0.1	0.0	5
Middlesex	819	8.6	3.0	36
Monmouth *	5	0.1	0.0	0
Morris	102	1.1	2.0	28
Ocean *	0	0.0	0.0	0
Passaic	172	1.8	0.4	8
Salem *	0	0.0	0.0	0
Somerset *	0	0.0	0.0	0
Sussex	29	0.3	1.0	1
Union	227	2.4	1.0	8
Warren	0	0.0	0.0	0
TOTAL FOR STATE	9509	100.0	1.8	219

* The MP Plan will be introduced into these counties during Phase III of the demonstration. The number of MP Plan recipients shown for these counties represent recipients who originally enrolled in the Plan in either a Phase I or Phase II county and have since moved to a Phase III county.

Source: Office of Prepaid Health Care, Division of Medical Assistance and Human Services, New Jersey Department of Human Services.

filed against obstetricians. In an effort to encourage the participation of obstetricians, physician services related to pregnancy and delivery were not included in the capitation rates. Although the PCMs are still responsible for providing these services, the services are reimbursed at the regular Medicaid fee-for-services rates. According to MP Plan officials, the differential treatment of these obstetrical services in the reimbursement scheme constitutes a health status adjustment in recognition of the fact that physicians cannot control the need for these services through case management. Pediatrician attendance at at-risk vaginal deliveries or Caesarian sections and routine in-hospital newborn care were also not included in the capitation rates for the same reason.

The majority of the patients enrolled in the Plan are being seen by only a few of the PCMs. The five community health centers that have enrolled patients in the Plan provide care for twenty-three percent of the total Plan enrollment (see Table III). One-third of the Plan's patients are enrolled with one partnership practice in Essex County. This service pattern is similar to that of the fee-for-service portion of the Medicaid program in which a small number of providers account for the majority of the claims.

TABLE III

COMMUNITY HEALTH CENTERS
PARTICIPATING IN THE MP PLAN

<u>CENTER</u>	<u>LOCATION</u>	<u>NUMBER OF ENROLLEES</u> *
Calvary Baptist	Paterson, N.J. Passaic County	18
CamCare	Camden, N.J. Camden County	1100
Community Health Center of Paterson	Paterson, N.J. Passaic County	45
North Jersey Community Union	Newark, N.J. Essex County	533
Plainfield Neighborhood Health Center	Plainfield, N.J. Union County	209
	TOTAL	1905

* Number of enrollees as of June 1985.

Source: Office of Prepaid Health Care, Division of Medical Assistance and Human Services, New Jersey Department of Human Services.

CHAPTER TWO

OVERVIEW OF THE NEW JERSEY HEALTH CARE MARKET AND THE STATE MEDICAID PROGRAM

A. New Jersey Health Care Market

In assessing the development and implementation of the MP Plan, it is useful to view the program in the context of the total state Medicaid program and the larger New Jersey health care market. Looking at the program in a broader scope can lend a better understanding of those forces affecting it from the outside, independent of the internal operations of the demonstration.

DRG System

Since 1978, New Jersey's acute care hospitals have been paid on the basis of diagnosis-related group (DRG) hospital payment rates. The DRG-based reimbursement system began as a federally funded experiment and as such, became the forerunner to the Medicare DRG-based prospective payment system enacted by Congress in 1983. Under the DRG system, hospitals are paid according to 468 fixed rates based on diagnosis, age, sex, discharge status, surgical procedures and secondary diagnosis, regardless of length of stay or services used. The rates are based on individual institutions' past costs and statewide hospital cost averages. All payers, including Medicare, Medicaid, Blue Cross, and private insurance companies, pay hospitals according to DRG rates.

The rates are calculated to include an allowance for the costs of uncompensated care. This allowance effectively covers any costs incurred by a hospital in treating MP Plan patients, in the event that the hospital fails to obtain the required prior authorization for treatment of an MP Plan enrollee. Although this uncompensated care allowance was recently renewed by the New Jersey state legislature, there is some question as to whether it will be continued in the future. If the allowance were eliminated, hospitals would be forced to absorb the cost of unauthorized care provided to MP Plan patients.

Statewide Health Care Supply Characteristics

At the end of 1980, the ratio of non-federal physicians in New Jersey to residents in the state was 177.5 per 100,000 residents compared to the national average of 197 per 100,000.¹ Medicaid officials report that although an estimated two-thirds of these physicians are certified to provide care to the Medicaid population, most of the Medicaid claims are accounted for by less than 10 percent of the physicians.

There was a total of 97 community hospitals providing 4.1 beds per 1000 population. The average occupancy rate for these hospitals in 1983 was 80.9 percent compared to the national average of 73.5 percent. The average length of stay was 8 days, compared to the national average of 7.6 days. Over the five-year period from 1978 to 1983, during the implementation of the all-payer DRG system, the average length of stay in New Jersey community hospitals decreased 9.1 percent. The number of

admissions per 1000 population was 151 in 1983; this represented an 8.6 percent increase since 1978.²

The HMO market in New Jersey is experiencing a period of rapid growth. As of June 1984, 4 percent of the state population was enrolled in the ten HMOs operating in New Jersey.³ HMO enrollment increased 44.3 percent from December 1983 to December 1984.⁴ Observers expect this growth trend to continue.

Two of the HMOs recently received approval from the state Department of Health to expand their operations. CoMed, an IPA-model HMO based in Essex County, is expanding from one county into six additional counties. HMO of New Jersey, currently operating in ten counties, is in the process of becoming the first statewide HMO in New Jersey. Crossroads Health Plan has been bought by AmeriCare, a for-profit health care organization based in California.⁵ In addition, Prudential Health Insurance Company of Newark recently announced that it will offer a new group health insurance plan in New Jersey that will combine HMO and preferred provider arrangement features.⁶

The effect of this increased HMO activity has been to make physicians and patients more familiar with prepayment and capitated reimbursement systems, as well as with the case management concept. There is some indication that this has had a favorable impact on the MP Plan. Physicians in areas where HMOs are operating have generally been more interested in the Plan than those in areas without HMOs. Plan officials have also noted as they have begun marketing for Phase III that there has been an increased interest in the MP Plan among physicians. They attribute this, in part, to the greater prominence of HMOs.

Phase I, II and III Counties

The Phase I counties are rural and suburban counties having small Medicaid populations. The state chose to begin the demonstration in these counties to work out any administrative and implementation problems before enrolling large numbers of Medicaid eligibles in later phases. Only seven percent of the physicians in New Jersey practice in these counties. The Phase I PSRO estimated that there were approximately 500 primary care physicians practicing in the three counties. Only twenty-one physicians participated as case managers in Phase I.

Plan officials cited two reasons for the low rate of physician participation. First, because of the small Medicaid population in these counties, physicians tend to have a small number of Medicaid patients. They feared that the MP Plan would expose them to undue risk if one patient was in need of large amounts of health care services. Second, many physicians were unfamiliar with, and therefore resistant to, prepayment and capitated reimbursement systems. Physicians in these counties were willing to do business as usual; that is, to provide services to the Medicaid population despite the existing low reimbursement rates because they feel that it is part of their social responsibility.

The Phase II counties (including the three counties that were phased in midway through the Phase II period -- Essex, Passaic, and Union) comprise the major urban areas of the state - Camden, Trenton, Atlantic City, New Brunswick and Newark. The majority (63.7 percent) of the state's Medicaid eligibles are concentrated in these counties. Physicians in the Phase II counties are more familiar with prepayment and capitation systems because several HMOs operate in these counties.

They are also more likely to have large Medicaid practices that would allow them to limit their exposure to the financial risk associated with the MP Plan. Because there are more physicians concentrated in smaller geographical areas in the Phase II counties, these physicians expressed more concern about protecting their market share of patients.

The Phase III counties include the remaining ten counties in the state--Bergen, Cape May, Cumberland, Gloucester, Hudson, Hunterdon, Monmouth, Ocean, Salem and Somerset. Thirty-two percent of the state's Medicaid eligibles are located in these predominately rural and suburban counties.

B. Programs within the New Jersey Medicaid Program

HMO Contracting

In addition to developing the MP Plan, OPHC is conducting a separate effort to contract with HMOs to serve the Medicaid population. In 1983 DMAHS contracted with OMNICARE, an HMO serving southern coastal counties, to provide care to Medicaid recipients. As of May 1985, OMNICARE had enrolled approximately 1000 Medicaid patients. DMAHS is currently seeking a contract with another HMO -- Health Care Plan of New Jersey.

According to one DMAHS staff member, "the state is not looking for a bargain in contracting with HMOs, rather it is looking for quality care for Medicaid eligibles." In keeping with this idea, the state only requires HMOs to bid at least 1 percent below the state-approved capitation rates. These rates are based on the average adjusted per

capita cost (AAPCC) of providing the standard Medicaid fee-for-service benefit package.

The developers of the MP Plan originally intended to have HMOs participate in the demonstration as case managers; it became apparent though, that the design of the MP Plan capitation system is not geared toward their participation. The Plan's payment system is arranged so that the state retains both the referral services portion and the inpatient services portion of the capitation payments on behalf of each PCM. There are also limited and no-risk provisions associated with each of these funds. HMOs, on the other hand, typically receive the total capitation payment amount upfront and are at full risk for all services delivered to their members.

Not only were HMOs reluctant to participate because the Plan could not offer them enough money up front in prepayments, they also found the Plan unattractive because any surpluses in the Referral Services Fund and the Inpatient Fund could only be realized when the accounts were reconciled (at six month and one year intervals). Furthermore, HMOs are still skeptical of the state's commitment to prompt payment schedules. They are not convinced that a Medicaid contract would ensure them an adequate cash flow.

In addition to questions of cash flow, HMOs have expressed other concerns about risks associated with serving Medicaid patients. There is a feeling that the Medicaid population is "atypical". For this reason HMOs are hesitant to become involved in the delivery of care to this population. Some HMO representatives anticipate that there would be a large number of grievances or complaints from Medicaid patients arising out of a misunderstanding of the HMO concept. OMNICARE's

willingness to contract with DMAHS stems in part from the fact that it was formerly a neighborhood health center, and thus had previous experience in providing care to the Medicaid population.

HMOs, as well as other providers, expressed concern about the fragmented Medicaid eligibility process which makes it difficult to obtain eligibility information. Without access to up-to-date eligibility information, the HMO may find itself providing care to patients who are no longer eligible. OMNICARE has encountered this problem. There is a one month lag between the time a recipient loses eligibility and the time that OMNICARE is notified of the change in eligibility status.

During this period of rapid growth and expansion, the HMOs are targeting private payers for enrollment in an effort to establish themselves and increase their market. Given this situation, it seems likely that they will be reluctant, at least initially, to serve the Medicaid population.

Medically Needy Bill

The governor of New Jersey signed a bill in November 1985 that expands the state's Medicaid program to include a medically needy component. According to a state assemblyman, New Jersey has considered a medically needy program for years, but lack of funding has always been a barrier to instituting one. The current state budget surplus provided the impetus necessary to pass the legislation this year. The program will be funded out of general revenues and New Jersey's casino tax fund. The Federal Government will contribute approximately 50 percent of the annual costs.

The program is scheduled to go into effect in April 1986. It will cover an estimated 3,000 pregnant women, 100,000 dependent children under the age of twenty-one, 90,000 aged and 12,500 blind and disabled persons. At the time of the site visit, planning was already underway to make the program operational. Some members of the Plan staff indicated that concern within DMAHS about implementing the new Medically Needy component has resulted in less attention for the MP Plan, and has made it difficult to garner political support for the demonstration.

CHAPTER THREE

MP PLAN DEVELOPMENT AND IMPLEMENTATION

A. Overview of Major Changes

MP Plan Administrative Structure

The administrative structure of the MP Plan has undergone several major changes during the implementation of Phase II. Originally, the staff of OPHC intended to rely on outside organizations to perform most of the administrative functions. The OPHC staff, consisting of six persons, was to act as a central coordinator for the program. All members of the staff had other areas of responsibility within DMAHS in addition to the administration of the MP Plan. The three outside groups with primary responsibility for administering the Plan were to be the PSROs (acting as brokers), the county welfare agencies (CWAs), and La Jolla Management, Inc.

As the demonstration has progressed, however, the Plan staff has found it necessary to modify, and in some cases to transfer, the original roles of each of these groups. In the course of these changes, the MP Plan staff assumed an expanded role in the administration of the Plan during Phase II. Consequently, staff resources have been severely strained under the increased workload. OPHC was able to hire employees paid on an hourly basis (as opposed to full-time, salaried staff members) to assist in the areas of marketing

and enrollment during Phase II. In addition, DMAHS officials have recently approved the hiring of another 35 hourly employees to assist in the implementation of Phase III of the Plan.

PSROs as Broker

The PSRO, originally a key component of the MP Plan, was to function as a liaison between the Plan staff and the other participants in the Plan - physicians, recipients, claims processing contractors, and county welfare agencies. As outlined in the operational protocol, the PSRO's role included the following responsibilities:

- o primary responsibility for marketing the Plan to providers;
- o enrolling primary care physicians in the Plan;
- o acting as a liaison between physicians and their enrollees;
- o operating a grievance system;
- o developing and implementing a quality assurance system;
- o and partial responsibility for marketing to and enrolling Medicaid eligibles.

The task force chose PSROs to act as brokers because they felt that they were the organizations best suited for the role, due to their established relationships with physicians and hospitals in the communities and their experience in utilization review and quality assurance programs. The Phase I broker was the Area I-Region II PSRO, and the newly formed PRO of New Jersey was chosen as the broker for Phase II. The state originally planned that brokers for subsequent phases would be selected through a formal bidding process. In addition to PSROs or PROs, the state intended to consider health systems

agencies, insurance carriers, and consulting firms as possible organizations that could fill the broker role.

Because using PSROs as brokers was an innovative concept, the task force anticipated that the PSROs' role would be modified over the course of the demonstration as experience required. In retrospect, it is apparent that at the outset of the demonstration the state and the brokers lacked the experience that was necessary to define specific responsibilities, tasks, and guidelines in a reasonable manner. As a result, the two parties spent much time negotiating responsibilities.

As the demonstration progressed, it also became clear that the PSROs were not appropriate entities for the broker role as it was defined in the operating protocol. In March 1985, after reassessing the broker role, the staff submitted an amendment to the operational protocol requesting that HCFA permit OPHC staff to assume all of the current broker functions after a five-month transition period. This change was prompted by the fact that the Plan staff had already gradually taken on many of the broker responsibilities over the course of Phase II. Moreover, negotiations with the brokers were consuming excessive amounts of time and energy. The Plan staff felt it would be a more efficient use of their personnel and financial resources to assume the responsibilities themselves, and that OPHC could perform these functions more effectively than the PSROs.

State officials expressed disappointment that the PSROs were not more aggressive in their role as brokers. In particular, they cited three areas where the PSROs were ineffective: marketing the Plan to physicians; managing the Medicaid-eligible enrollment process; and contributing to the development of the quality assurance system. In

the areas of marketing and enrollment, OPHC staff became involved both in training CWA staff and in assisting them in enrolling Medicaid eligibles. They also hired an additional staff member to launch a marketing campaign directed at physicians in Phase II and Phase III counties.

The state had expected the PSROs to be most helpful in developing and implementing a quality assurance system for the demonstration, especially given their experience in this area. According to the Phase II broker, though, the PRO did not have the opportunity to work on a quality assurance system before it was agreed that they would be phased out of the demonstration. The brokers maintained that the state had unrealistic expectations of the work that could be performed within the given time and budget frameworks.

Contract negotiations proved to be a major point of contention between the two parties. The issues surrounding the negotiations included the broker's desire for decreased responsibility, increased reimbursement and an open-ended contract that would allow for adjustments in the amount paid to the PSRO. Both the Phase I and Phase II brokers have stated that the funds that were allocated to them were inadequate, given the scope of the work that they were expected to perform. The Office of Purchase and Property in the New Jersey Department of Treasury has concurred with this viewpoint. The total budget for the Phase I broker over a 15-month period was \$60,000. The Phase II broker activities were budgeted at \$180,000 for a one-year period.

During the negotiations, the state insisted on broker accountability by requesting that the two organizations develop cost accounting

and invoicing procedures for broker tasks. The Phase I broker notified the state that it did not intend to seek renewal of its contract because it was not willing to cooperate with the state in developing and following these procedures. The Phase II broker also resisted adopting any formalized accountability procedures.

The state was finally able to sign a contract with the Phase II broker in February 1985. However, this contract only covered a five-month period from June 1984 through October 1984. The contract for the broker's work for the period November 1984 through July 1985 was finalized in June 1985. In August 1985 the state terminated its relationship with the PRO, and subsequently assumed all broker responsibilities.

It should be noted that two external influences unrelated to the MP Plan affected the brokers' ability to perform their intended functions. The first factor was the PRO selection process. After the implementation of the Medicare DRG-based prospective payment system in October 1983, one PRO would be chosen by HCFA to perform the utilization review function for the entire state. Both the Phase I and Phase II PSROs were bidding for this job in New Jersey. The Plan staff feels that in some sense the PSROs viewed their contract to serve as MP Plan brokers as a backup should they not contract with HCFA to serve as the statewide PRO for the Medicare program. As a result, the state believes that their preoccupation with the PRO selection process detracted from the PSROs' commitment to the MP Plan.

The second external factor that affected the brokers' ability to function was the providers' changing perception of PSROs. In choosing PSROs as brokers, the state sought to take advantage of their

established relationships with physicians and hospitals. However, because of the increasing pressure on PSROs to ensure cost efficient behavior, they are more often viewed by hospitals and physicians as regulatory organizations. As a result, in some instances it was more difficult for the brokers to establish credibility with providers.

County Welfare Agencies' Role

The role of the county welfare agencies has also been modified. The CWAs were originally to be the primary site for enrollment. As early as Phase I, though, it became apparent that the CWAs were not effective in enrolling recipients in the Plan for two reasons.

First, the setting is not appropriate for marketing the Plan. The CWA is not the most conducive setting for discussing health care benefit options. Persons who come into the office are usually there because of a crisis and are often anxious about applying for government aid. Often they are receiving a large amount of information and filling out a variety of forms, and thus it is easy for them to misunderstand or completely forget any information that they receive regarding the MP Plan.

Second, it was found that most Medicaid recipients rarely go to the CWA unless they have a problem with their welfare payments, or are first-time eligibles applying for welfare. As a result, the CWA was not a good place to contact large numbers of potential enrollees.

In addition to the fact that the setting was somewhat inappropriate, some county welfare workers also expressed resistance to the MP Plan alternative. They have no incentive for enrolling eligibles into the Plan and find that presenting the MP plan option to

recipients only adds to their workload. Thus, there is some question as to whether the CWA staff can effectively present the Medicaid options in a thorough and unbiased manner.

In order to increase the Plan enrollment, the Plan staff developed an on-site enrollment process. PCMs can now enroll a Medicaid recipient in their offices when the recipient comes in for a visit. Although this on-site enrollment has been effective in increasing enrollment, it opens up the possibility for biased selection. This new enrollment procedure is discussed more fully in the section on marketing and enrollment of Medicaid eligibles.

The CWAs still remain the site for enrolling first-time Medicaid eligibles. In addition, the CWAs are integrally involved in the MP Plan as the clearinghouse for all eligibility and enrollment information. They work closely with the state's fiscal intermediaries (Blue Cross and Prudential) and the MP Plan staff in maintaining eligibility files.

La Jolla Management Corporation's Role

La Jolla Management, Inc., a consulting firm, has had an on-going role in the development and implementation of the demonstration. The proposal for the demonstration was drafted by La Jolla consultants and DMAHS staff. La Jolla's responsibilities in implementing the MP Plan originally included assisting the brokers in developing administrative mechanisms, assisting in the development of the management information system, and assisting in the development of the capitation system. In addition, La Jolla took responsibility for enrolling Medicaid eligibles

after the Phase II PSRO subcontracted with the firm to perform this function.

OPHC contracted with La Jolla to develop the management information system for the MP Plan in coordination with the existing Medicaid Management Information System (MMIS). Blue Cross and Prudential serve as the fiscal intermediaries for the New Jersey Medicaid program. Blue Cross maintains the Medicaid eligibility file and the MP Plan subfile that was developed as an addition to the MMIS. MP Plan enrollment information is channeled through the CWAs. The CWAs were responsible for directing this information to La Jolla, which would then add this information to the subfile via a terminal that interfaced with the Blue Cross MMIS. The Plan staff has now taken over the function of creating subfile records for new Plan enrollees.

In addition to coordinating the Plan's management information system (PMIS) and the MMIS, La Jolla was responsible for developing seven sets of management reports:

- Out-of-Plan Utilization and Expenditure Reports
- Financial Monitoring and Forecasting Reports
- PCM Prepayment Accounting Reports
- Referral Services Fund and Inpatient Services Fund Accounting Reports
- Service Utilization Reports
- Marketing Reports
- Administrative, Quality Assurance, and Grievance Reports

The PCM Prepayment Accounting reports and the Referral Services Fund and Inpatient Services Fund Accounting reports are currently available; however, due to programming delays, the other reports have not been developed yet. This raises some concerns because it would seem that the information contained in these other reports is essential for the effective and efficient administration of the demonstration.

La Jolla has also been involved in developing the capitation rates for the demonstration. The rate-setting process involves two steps. First, the New Jersey Department of Treasury determines the total amount of funds that will be allocated to each actuarial category of MP Plan enrollees for capitation payments in a given year. (Actuarial categories are determined on the basis of age, gender, county of residence and eligibility category.) This allocation is set at 95 percent of the actual expenditures for the Plan benefits package under the fee-for-service Medicaid program for the base year and adjusted for inflation.

The second step is for La Jolla to divide the total amount among the three capitation funds -- the Primary Care Prepayment Fund, the Referral Services Fund and the Inpatient Services Fund. The amount credited to these funds for each enrollee varies according to the enrollee's actuarial category. The Plan staff reported that La Jolla has used inconsistent methodologies in determining the allocation of the total capitation amount for each phase of the demonstration. Furthermore, according to state officials, as a result of changes in La Jolla's staff, the methodologies used during the first two phases were not documented.

The initial Phase III rate-setting methodology yielded rates that were dramatically lower, overall, than the Phase II rates. An OPHC staff member attributed the decrease to the use of a different rate-setting methodology and the removal of mental health services from the capitation rates. State officials feared that the lower rates would make it difficult to market the Plan to Phase II PCMs who received higher rates last year; therefore, the staff made a decision to use

what they have termed "transitional" rates in fiscal year 1985. These rates were derived by shifting dollars between inpatient and ambulatory capitation accounts in such a way that the changes in the rates are budget neutral with respect to state expenditures.

Although the adjustments have made the rates more marketable to physicians, the apparent basis for changing the rates to make them more attractive is unclear. The possible effects of using a different rate-setting methodology during each phase of the demonstration cannot be determined at this time. It may be difficult to assess whether the financial status of PCMs during each phase of the demonstration should be attributed to changes in practice patterns, or to changes in the amounts of the capitation payments as determined by the various methodologies used.

Over the course of the demonstration, the OPHC staff became increasingly dissatisfied with La Jolla's performance in terms of both quality and timeliness. As a result, La Jolla's responsibilities have been limited to developing the remaining Plan management reports. This represents a substantial curtailment of the firm's original responsibilities. As in the case of the PSROs, the staff felt that it would be a more efficient use of their time and financial resources to perform the other functions in-house.

Risk Waiver

During Phase I the state decided to waive the financial risk for the first year of participation for PCMs who join the Plan within the first 90 days of each new phase. This represented another major change in the Plan from what was originally proposed. This waiver of risk was

designed to encourage physicians to participate in the Plan. The state will assume responsibility for any costs incurred by a patient in excess of the amount that was allocated to the Referral Services Fund for that patient.

The risk waiver has had the desired effect of encouraging physicians to join the Plan; however, it remains to be seen how many physicians will renew their contracts after the first year of risk-free participation. The reconciliation reports that will allow the PCMs to assess their financial performance during the first six months of Phase II were made available to the PCMs in July 1985. Members of the Plan staff are optimistic that the majority of the Phase II PCMs will renew their contracts for a second year without the risk waiver.

B. Physician Marketing and Enrollment

It was originally intended that the broker would be primarily responsible for marketing the Plan to physicians and for enrolling them. Experience from Phase I showed that mass marketing techniques (e.g. presenting the Plan to groups of physicians at county medical society meetings) were not effective in selling the Plan to the doctors. When groups of physicians were gathered, any negative feelings regarding the Medicaid program in particular, or government involvement in health care in general, tended to dominate the discussion. The marketing staff found itself having to defend the MP Plan and the Medicaid program rather than selling the Plan. It was very difficult

to offer a clear presentation. This experience made it evident that the Plan could be most successfully marketed on a one-on-one basis.

The Phase II broker began marketing the Plan to physicians in August 1984. Although one-on-one marketing had proved most effective, the board of the PRO of New Jersey decided not to market the Plan in this manner. It felt that in light of its other activities, the PRO had a responsibility to remain neutral in its support of the MP Plan. Any door-to-door marketing of the Plan might appear as if the PRO was endorsing the Plan and trying to sell it to physicians. Constrained by these political considerations, the PRO conducted most of the marketing over the telephone. Physicians received a mailing describing the MP Plan and were instructed either to call the PRO or come into the office if they were interested. Only two physicians came into the office for further information.

In February 1985, a member of the staff of the Deputy Commissioner of Medicaid took over the job of marketing the Plan to physicians in Phase II counties. The impetus for this change was the fact that so few physicians had enrolled that the success of the demonstration was in jeopardy. This person adopted a new approach to marketing the Plan. First, he identified both individual providers with large Medicaid panels and networks of Medicaid-certified physicians. He then called on these physicians in their offices and presented the MP Plan to them on an individual basis. Among the approximately 300 physicians that he contacted in Phase II counties, he was able to have 150 of those physicians agree to sign contracts with the MP Plan.

Considering that many physicians have little, or no, experience with prepayment and capitated reimbursement systems, a one-on-one

encounter allows for the Plan to be discussed more thoroughly and for the physicians to have any personal questions answered. The personalized marketing approach also serves to demonstrate the commitment of OPHC staff to the MP Plan. The marketing staff feels that this display of commitment can help overcome some of the negative feelings about the Medicaid program held by many physicians.

Some observers have expressed concern that the MP Plan capitation system, which is discussed below, is so complicated that many physicians may not fully understand its workings. Several case managers who have had positive experiences with the Plan have expressed an interest in talking to nonparticipating physicians about the Plan. They believe that if the capitation system is explained in a careful manner, the reluctant or skeptical physicians would better understand the financial benefits of the Plan and be more inclined to participate. The OPHC marketing team has begun to take advantage of the opportunity to engage participating physicians in the marketing process; however, the potential for this marketing strategy still remains to be developed to its fullest extent.

During Phase I there were more Medicaid recipients interested in the Plan than there were primary care case managers to accommodate them. A disproportionate number of pediatricians signed up as case managers. Applications for Medicaid are handled on a case basis rather than on an individual basis. In order for a Medicaid family to enroll in the Plan, each member of the family must sign up with a physician. Although there was a sufficient number of pediatricians to be matched with the children, many families were unable to enroll because there

were not enough adult care physicians signed up as case managers. The Plan staff has not encountered this problem in the Phase II counties.

Marketing for Phase III began in May 1985. MP Plan officials report that between 150 and 200 physicians have expressed interest in joining the Plan. However, none of the physicians have been able to sign a contract yet because the implementation of the final phase of the program has been postponed.

C. Marketing to and Enrolling Medicaid Eligibles

As with physicians, there have also been significant changes made in the procedure for marketing to and enrolling Medicaid eligibles. During Phase I, enrollment in the Plan took place at the county welfare agency (CWA). All newly-eligible persons and those coming in for recertification were given the option of enrolling in the MP Plan, rather than participating in the regular fee-for-service program. This process of enrollment proved to be ineffective for reasons outlined earlier in the report (infrequent need for Medicaid recipients to visit the CWA office; inappropriate setting and time for discussing health care benefit options; and lack of commitment on the part of CWA social workers).

In the summer of 1984, the MP Plan staff began implementing the on-site enrollment process at physicians' offices. Members of the staff, as well as graduate students from Rutgers University hired by DMAHS, were stationed in participating physicians' offices to explain the MP Plan to Medicaid patients who came into the offices and

expressed an interest in the Plan. If they desired to join it, they were enrolled on-site. The majority of Phase II Plan members were enrolled through this process.

Although the MP Plan staff initiated on-site enrollment, it soon became evident that its own resources--one full-time person and two hourly employees to cover all of the Phase I and Phase II counties--were not adequate to handle this job. To address this problem, the MP Plan staff began offering seminars in February 1985 to train physicians' office staffs to perform this function. Any physician who would like to have Medicaid patients enrolled on-site must send office staff to these training seminars. The Phase II broker was involved in designing and organizing these seminars. They consist of training the office staff how to inform the interested Medicaid patients about the Plan in an unbiased manner and how to complete the paperwork. Twenty-two PCM office staffs have received the necessary training that allows them to do on-site enrollment.

There is some concern that on-site enrollment might promote favorable selection by the PCM; that is, the physician may encourage healthy patients to sign up for the MP Plan, and discourage sick patients from enrolling. The OPHC staff acknowledged that it is aware of the potential for biased selection, but felt that it could be addressed through on-site monitoring. This will be done by employees from the state Medicaid office questioning a random sample of enrollees and making off-hours site visits to physicians' offices. In addition to the monitoring, the PCM is required to sign a statement agreeing that he will present the two Medicaid options in an unbiased manner to all eligibles.

Another reason to be concerned about using on-site enrollment is that it does not reach those Medicaid eligibles who are not seeking care, or who are using the health care system inappropriately (e.g. seeking routine care in hospital emergency rooms). The patients who are being enrolled in physicians' offices are likely to have an appropriate point of access since they are seeking care from a primary care physician. The patients who do not have a primary care physician need to be made aware of the MP Plan and given the opportunity to enroll, if the Plan is to meet the goal of increasing access to the health care system.

D. Case Management

In a case management model the primary care physician serves as the patient's point of access to the health care system. The objectives of this model are to increase the continuity and the quality of care that the patient receives by decreasing the use of inappropriate health care services. By promoting the efficient use of the health care system, the case management model has the potential for decreasing the cost of providing health care, and at the same time improving the health of the population served.

There are several components to an effective case management system. These components are listed below and each is discussed with respect to how case management is being performed under the MP Plan.

The components are as follows:

- strict prior authorization controls
- patient responsibility
- management information reports
- utilization review and quality assurance

Prior Authorization: The PCM must authorize the delivery of any medical care or services that he or she does not provide to the beneficiary. This includes referrals to specialists, prescriptions and lab services. The PCM authorizes services and referrals by using a referral form. The provider of specialist care or ancillary services then submits a claim directly to Medicaid. The PCM's name and Individual Medicaid Physician (IMP) number are included on the claim form, indicating to the claims processing agent that the cost of the claim should be deducted from the PCM's referral services fund.

The prior authorization procedure has not been effective because physicians have not felt compelled to adhere to it. According to the Phase II broker, many physicians are confused about when and how to use the forms. Some specialists are not aware that they need to obtain a referral form from the case manager in order to treat an MP Plan patient. In many cases specialists will treat the patient and then find out that to receive payment on a claim they must get retroactive authorization from the PCM. At this point the PCM must decide whether to authorize the care retroactively.

It appears that in most cases the PCM does give retroactive authorization. One reason for this is that PCMs must maintain an ongoing relationship with their patients and colleagues after the

demonstration ends next year; therefore, they do not want to risk angering the patient or the specialist by denying an authorization request. Furthermore, the PCM was most likely still covered by the risk waiver. This being the case, there was no incentive to deny the authorization because the physician was not at financial risk for the services that were provided.

Several PCMs reported cases where the specialist knew the case manager's identification number from previous encounters with the PCM's patients and would simply enter this number on the claim form without notifying the case manager. In effect the specialist was indicating that he or she had received authorization from the PCM, when in fact that case manager had no idea that the specialist had treated his or her MP Plan patient.

For the prior authorization process to be effective, hospitals must also comply by contacting the PCM when an MP Plan enrollee appears at the emergency room for nonemergency care. Physicians report that they are not getting calls from the hospital emergency rooms concerning their MP Plan patients. MP Plan patients often fail to show their identification cards. At other times, the emergency room staff are not familiar with the MP Plan gold card and do not know that they must get prior authorization from the case manager. If an MP Plan patient is given nonemergency care at the hospital without prior authorization, there are two possible outcomes: the PCM can authorize the treatment retroactively, or the hospital can absorb the cost of the treatment because the claim is rejected.

In a recent newsletter sent out to providers, the Plan staff indicated that the prior authorization procedure will now be strictly enforced and claims for unauthorized care will not be paid.

Patient Responsibility: Physicians and hospital personnel concurred that patient participation is essential in order for a case management system to be effective. Participation requires that patients understand and comply with the prior authorization procedure, and that they seek care through their chosen PCM rather than through other providers. Many MP Plan enrollees, particularly in urban areas, continue to seek care in the emergency room and refer themselves to physicians other than their case managers.

One emergency room staff person maintained that a large proportion of MP Plan patients do not understand how the case management system operates. They are not aware that they must contact their PCM before receiving nonemergency care in the emergency room.

In addition to not understanding the case management system, MP Plan enrollees often purposely fail to comply with the system. Hospitals report that one of the central problems in enforcing the prior authorization procedure is the fact that many MP Plan patients do not show their Medicaid cards when they come to the ER for care, even when asked to do so. In these cases, the ER staff has no means of identifying them as MP Plan patients.

PCMs also report that their MP Plan patients continue to engage in doctor-shopping rather than using the PCM as the point of access to the health care system. Because some PCMs and specialists do not strictly adhere to the prior authorization procedure, patients are often not

aware that they are not complying with the requirements of the case management system when they seek care from multiple physicians.

Part of the non-compliance problem appears to stem from the lack of incentives inherent in a voluntary program. One physician described Medicaid as a security blanket for the person on welfare and suggested that a new program such as the MP Plan is threatening because it lacks the familiarity of the traditional program. The convenience afforded by the fee-for-service system becomes more attractive than the continuity of care that the MP Plan might offer. Because the fee-for-service system is still an alternative for the MP Plan enrollee after the initial enrollment period ends, the enrollee has very little motivation for adjusting to the MP Plan and complying with its rules.

Management Information Reports: PCMs are to receive two sets of reports to assist them in their case management responsibilities--PCM Prepayment Accounting reports and Referral Services and Inpatient Services Accounting reports. The PCM Prepayment Accounting reports contain the following information:

- o enrollees in the PCMs panel by capitation category
- o changes in enrollees
- o monthly capitation rates for each category
- o total monthly capitation payments by category
- o cumulative capitation payments by category
- o a panel directory containing detailed information on active and terminated enrollees

The Referral Services Fund and Inpatient Services Fund Accounting reports contain the following information:

- o a financial summary of Fund accruals for the month, including paid claims and net balances
- o detailed and summary financial data for all referral and inpatient service claims for the month by patient, procedure, and referral provider, admission, and DRG.

These management reports have not been made available to PCMs in a timely manner. At the time of the site visit there was a four-month lag time in the distribution of monthly accounting reports. Plan officials cite difficulties with the management informations systems contractor as the reason for the delay.

Many physicians were dissatisfied with the format of the Referral Services Fund reports. The main problem is that referral specialists and diagnoses appear on the printouts as numerical codes. Interpreting the reports requires the time consuming matching of these numerical codes and names. A PCM cannot look at a report and readily determine which specialists have been treating his or her patients for which illnesses. Effective case management requires that physicians be able to monitor and coordinate specialist care and ancillary services. Without readable reports, PCMs cannot do this. Furthermore, the costs of these services provided by the specialists are being deducted from the Referral Services Fund so PCMs have a financial interest in tracking them.

The MP Plan staff has discussed with the La Jolla programming staff the possibility of identifying diagnoses and referral specialists by name, rather than by numerical codes. This change in the format would be complicated and time consuming. In light of the fact that the programming staff is currently developing other necessary reports, changes in the Referral Services Fund report are not being given high priority at this time.

Utilization Review and Quality Assurance: The incentives in the MP Plan that promote cost-efficient delivery of care have the potential for encouraging under-utilization of health care services; therefore, the

quality of care available to MP Plan patients needs to be monitored through a comprehensive utilization and quality assurance system. It may be difficult to determine the effects of the incentives because physicians were not at risk during their first year of participation. Some physicians reported that because they were not at risk, they did nothing to alter their practice patterns in order to determine if the Plan could still be profitable, given their current practice pattern. Others took advantage of the risk waiver to become more conscious of practicing case management to determine the financial effects of the Plan under such a system.

For those physicians who are at risk, the incentives to provide less care are clearly more likely to come into play. For the purpose of evaluation it will be difficult to compare utilization trends of a physician who was not at risk with the utilization trends of a physician who was at risk. Any evaluation of utilization trends should distinguish between the two classes of physicians.

The Phase I broker conducted a small scale quality assurance study in the Phase I counties. The PSRO reviewed recipient profiles for sentinel health events and found no indications of inappropriate utilization or suboptimal care. Three grievances were reported during Phase I. These were resolved to the satisfaction of all parties concerned. As part of the study the broker mailed a patient satisfaction survey to former MP Plan members but there was no response to the survey. The study concluded that "the care provided to MP Plan members by PCMs met the optimal standards of patient care." However, because of the small number of enrollees in Phase I, the study did not produce any statistically significant results.

The Plan staff is now engaging in its own, expanded efforts of developing and implementing a utilization review and quality assurance system. The various components of the system as it presently exists are described in the remainder of this section.

The MP Plan staff has developed ambulatory practice guidelines for two diagnoses -- gastroenteritis and streptococcal pharyngitis -- and for immunizations for ages zero through six months. These guidelines have been submitted for review to the MP Plan state-level advisory committee and are awaiting approval. After they are approved, the Plan staff will request MP Plan patient records from PCMs to determine if the guidelines have been followed.

The sentinel events monitoring will be limited to a post-audit of claims data. The Plan staff will use the Systemetrics disease-staging system for monitoring. Specific diseases and sentinel events have been chosen for review. PCMs are required to submit dummy claims for each patient encounter. The information on these forms, as well as the information on actual claims submitted for referral services and inpatient care, will be used to monitor both utilization and quality of care.

The development of the utilization review process has been hindered by the delays in the development of the management information reports and by the failure of the brokers to perform any substantive work in this area. Now that the PSROs are no longer involved in the MP Plan, any utilization monitoring activities will necessarily be performed by the Plan staff. OPHC employs a nurse who has taken on some of the utilization review responsibilities. But, if the Plan continues

to operate under tight staffing pressures, it is probable that these activities will be limited in scope.

Members of the Plan staff set up an ongoing telephone survey of MP Plan participants. The survey is intended to measure patient satisfaction with the program. Recipients calling in to disenroll are administered a questionnaire over the phone. MP Plan officials report that preliminary results indicate overall satisfaction with the Plan, with the exception of expressed dissatisfaction with having to obtain a referral form for specialist care.

E. Ambulatory Services Capitation System

Capitation rates for ambulatory services are based on actual claims data from July 1982 through September 1983 and eligibility data from July 1982 through June 1983. The methodology allowed for an average three month lag in claims payment by using claims data from the three months following the end of the eligibility period. To adjust for differences in utilization among patients and costs in different areas, Medicaid eligibles were grouped into actuarial categories according to age, gender, county of residence, and category of eligibility. Because claims data include this information, it was possible to match services used by groups of patients with payments made. Claims for services and for eligibles potentially not covered or included in the MP Plan were purged from these files.

The remaining claims were matched to eligibles to get a total annual cost for each. Average costs per eligible for each actuarial

group were then calculated by summing per eligible costs and dividing by the number of eligibles. This resulted in the monthly ambulatory services average cost per eligible (ACPE) for each category.

The ambulatory ACPEs are increased by 5 percent per year to account for inflation and by 2 percent to reflect claims payments lags. A deduction of approximately 20 percent of the inflated ambulatory ACPE is made for a contribution to the state reinsurance fund. The state maintains this fund to cover the costs of services that exceed the providers' liability (discussed below). The balance of the inflated ACPE is the Monthly Capitation which is allocated to each PCM for each Plan enrollee. This is divided into the Monthly Primary Care Prepayment, the Referral Services Fund allocation, and the Inpatient Capitation. (See Table IV on page 45 for sample capitation rates.)

The Monthly Primary Care Prepayment is intended to cover the cost of primary care services that the PCM provides directly to enrollees. The portion of the total capitation allocated to the primary care prepayment is based on historical fee-for-service expenditures for services delivered by primary care physicians, non-specialty clinics, and 75 percent of the services provided in hospital emergency rooms. Taking into account that Medicaid beneficiaries use excessive amounts of inappropriate primary care services in comparison with the general population, state officials believe that PCMs can receive higher payments per visit than the Monthly Primary Care Prepayment amount if they can reduce utilization of hospital emergency rooms and the incidence of self-referrals and doctor-shopping through case management.

The Referral Services Fund is maintained by the state to pay for ambulatory care not provided by the PCM, such as pharmacy, specialist, X-ray, and laboratory services. Each month a portion of the Monthly Capitation is credited to the PCM's referral services account for each MP Plan enrollee. Providers of referral services are reimbursed on a fee-for-service basis by the state through its existing claims payment system. These payments are deducted from the PCM's account.

State officials have analyzed the actual costs of referral services against the amounts that were contributed to the Referral Services Fund to see whether PCMs would lose money, given current utilization patterns. Their results based on this analysis showed that if utilization and costs remain unchanged, PCMs stand to profit.

The ambulatory capitation system contains a stop-loss provision for referral services. The state calls this the Provider Liability, the maximum monthly amount per patient for referral services for which the PCM is at risk. For an average AFDC patient, the Provider Liability was \$36.16 per month during Phase II. (It is not clear how the state determined this figure.) If expenditures for referral services exceed the Provider Liability, the state is at risk.

Reconciliation for referral services accounts for each patient occurs three months after the end of each six-month period. These balances are then netted across all patients in the PCM's panel for a final reconciliation balance. A positive balance means that overall credits exceeded claims and the PCM is sent a check. A negative balance means that claims paid exceeded credits and that the PCM owes the state. However, the PCM can carry such deficit forward for another six months.

In addition to the Primary Care Prepayment and the referral services allocation, PCMs receive a case management fee of \$2.00 per enrollee. The fee is taken out the allocated ACPE before the funds are divided into the three separate capitation accounts. The PCM receives this fee regardless of the balance in his or her accounts. It was introduced in Phase II to encourage physicians who are reluctant to expose themselves to the financial risks of prepayment and capitation to join the Plan . The fee assures them of some financial compensation for acting as case managers.

F. Inpatient Services Capitation System

A separate capitation system was developed for inpatient care. It is an incentive-only system that allows PCMs the possibility of financial gain, but protects them from financial loss. The state felt that because the costs incurred in hospitalization are generally much higher and not as easily controlled as the costs associated with ambulatory care, physicians would not be as willing to accept the financial risk posed by capitating inpatient care. Thus, the inpatient services capitation system was structured so that physicians can benefit from controlling the use of inpatient hospitalization services, but not be penalized for providing needed services that may be expensive, unpredictable or uncontrollable.

The inpatient services fund is maintained on two levels: the individual PCM level and the regional level. The regional level

TABLE IV

SAMPLE PHASE II CAPITATION RATES

	<u>Average AFDC</u>	<u>Average OAA</u>	<u>Average Blind/Disabled</u>
Monthly Capitation	\$55.11	\$75.80	\$140.18
Monthly Primary Care Capitation	8.38	5.79	20.48
Referral Services Capitation	13.48	31.94	46.66
Inpatient Capitation	33.25	38.07	73.04
Provider Liability (Referral Services Stop-Loss Limit)	36.16	101.66	134.44

Source: "Addendum II: Capitation Rates and Accounting Methodology,"
Paper prepared for DMAHS, March 5, 1984.

consists of all the PCMs in a given geographic area. Pooling capitation payments at the regional level is intended to minimize the financial risk associated with random hospitalizations by spreading this risk across a larger number of patients.

The fund is reconciled on an annual basis. At the time of reconciliation, the balances in each individual PCM's account are pooled across a given region. If the balance at the regional level is negative, the state pays the difference out of its reinsurance fund and a new accounting period is begun. The PCMs are not required to absorb any losses. If there is a net positive balance in the regional fund, the surplus is divided among the PCMs and the state. Those PCMs with positive balances in their individual accounts are rewarded with a larger share of the surplus.

Any surplus among the pooled balances is divided between the state and the PCMs in the following manner:

- 50 percent of the surplus is returned to the state's reinsurance fund, in recognition of the fact that the state bears full risk for the costs of hospitalization;
- 25 percent of the surplus is distributed to PCMs on the basis of panel size (i.e. the number of MP Plan enrollees in their practice), regardless of the amount that their individual account balance contributed to the total surplus (PCMs with larger than average panels of MP Plan enrollees will receive larger than average proportion of this 25 percent of the surplus);
- the remaining 25 percent is allocated to PCMs on the basis of the balance in their individual inpatient services funds (PCMs with a larger than average positive net balance will receive a larger proportion of this 25 percent of the regional surplus, while PCMs with negative balances in their individual accounts will not receive any of the portion of the surplus).

The above method of allocating the total net surplus enables the savings to be shared without penalizing individual physicians. At the same time it provides incentives for physicians to control hospital costs in a cost-effective manner by distributing some of the surplus on the basis of individual PCM account balances. Yet, because the savings are shared and there is no down-side risk, the effects of the incentives may be diminished. (See Appendix II for an example of how the inpatient capitation system works.)

The inpatient capitation system includes a stop-loss limit of \$10,000 for each patient; that is, if a patient incurs hospitalization costs above \$10,000 in a given year, the Plan's reinsurance fund will cover the additional amount. The effect of this provision is to prevent one patient with unusually high inpatient medical costs from draining the balance of the pooled Inpatient Services Fund.

The Plan also provides a Supplementary Ambulatory Reimbursement (SAR) that is designed to act as an incentive for physicians to consider outpatient treatment as an alternative to inpatient care when appropriate. In choosing to treat a patient on an ambulatory basis when hospitalization is also an option, the PCM must consider that outpatient care may require additional office visits and the use of ancillary services that would be reimbursed from the PCM's Referral Services Fund. Juxtaposing the inpatient and ambulatory capitation systems, there is an incentive to hospitalize rather than to be at direct risk for care delivered on an ambulatory basis, even though the alternative to hospitalization is more cost-effective overall. To counteract this disincentive, the Plan provides a payment of \$200 to

PCMs who choose to treat a patient on an ambulatory basis when it is medically appropriate.

The SAR is intended to compensate the PCM for additional time and attention required to provide care on an outpatient basis, and to offset debits that may have accrued to the PCM's Referral Services Fund as a result of choosing the outpatient alternative. Before a SAR is given to a PCM, the case must be reviewed by the OPHC medical staff to determine if it was medically appropriate to treat the patient on an ambulatory basis. The Plan staff report that none of the PCMs has applied for the SAR. One possible reason, according to several PCMs, may be that physicians perceive that applying for this additional compensation would lead to unwanted scrutiny of their practice patterns.

G. Financial Status

There are no definitive figures available at this time regarding the financial status of the MP Plan. In the absence of these reports, OPHC staff has estimated a 17 percent savings for the MP Plan in comparison with expenditures for the fee-for-service Medicaid program. This figure is based on the funds remaining in the State's reinsurance fund. Information regarding utilization trends that would support this estimate are not yet available.

CHAPTER FOUR

PROVIDER PERSPECTIVE

A. Factors Influencing Physicians' Decision to Participate

During Phase II, 190 physicians participated as case managers. According to the Phase II broker and the MP Plan staff, the reasons most often cited by physicians for signing up with the Plan included the potential for increased income from their Medicaid practices, a desire to protect their market share of patients, and an awareness that prepayment and capitation are "the wave of the future". Many physicians are willing to give the Plan a try because they will not be at financial risk during the first year of their participation. One physician estimated that a doctor would need to have at least 100 Medicaid patients enrolled in the Plan in order for it to be profitable.

Primary care physicians practicing in urban areas were most concerned about protecting their market shares. In these areas, the physicians are competing more directly with each other because other doctors enrolled in the MP Plan are easily accessible to MP Plan enrollees.

OPHC officials report that there has been an increase in the number of physicians requesting information about the MP Plan. This is in marked contrast to physicians' initial resistance to the Plan during

its developmental stages and during the Phase I marketing period. OPHC officials attribute this increased interest in the Plan to networking effects among physicians who have had positive experiences with the Plan, as well as to the increased visibility of HMOs and familiarity with prepayment and capitated payment systems.

Physician disenrollment has been minimal. One group of five physicians who did not have any MP Plan patients dropped out of the Plan after Phase I.

B. Financial Status of PCMs

Phase I physicians: Of the 21 physicians participating in Phase I, six accumulated surpluses in their prepayment and referral services accounts, and two had negative balances in these accounts; the remaining 13 physicians broke even. The surpluses ranged from \$15 to \$890. Of the two physician with negative account balances, one ran a \$15 deficit, while the other physician ran a \$331 deficit. According to Plan officials, the physician with the larger deficit was treating a disabled patient in need of more costly medical care.

Phase II physicians: There is no information available yet to indicate the financial status of the physicians participating in Phase II of the Plan because of problems with the information system. Physicians expressed a high degree of frustration over the fact that they were not receiving the Referral Services Fund Accounting reports in a timely manner. Without adequate and timely financial information PCMs cannot

keep track of their financial status and practice in accord with the Plan's financial incentives.

C. Case Management and Physician Behavior

Providers generally felt that the case management concept underlying the MP Plan is viable and that it has the potential for increasing access and continuity of care for the Medicaid population. However, providers felt that they would be better able to case manage if the program were made mandatory for all Medicaid eligibles.

Although the MP Plan gives the PCM financial incentives to adopt a cost-effective practice pattern, one physician expressed reluctance to respond to the incentives to change his practice patterns because he fears that he will be cited for promoting under-utilization. He would like to have access to a physician involved in administering the Plan with whom the PCM could confer and who could validate decisions regarding referrals or elected surgery that Plan physicians make as case managers. In his opinion, this type of support would enhance the operation of the case management system.

According to state officials, at this time OPHC does not have any intention of creating this type of position on the staff. They noted that both the director and the assistant director of the MP Plan are qualified medical doctors who could be consulted if necessary. But, they emphasized that it is reasonable to expect PCMs to be able to make case-management decisions on their own.

D. Hospitals

Emergency Room Use: In attempting to adhere to the prior authorization procedures, ER staff are confronted with the patients' lack of understanding of the system and their noncompliance in cases where they fail to identify themselves as MP Plan enrollees. One hospital official remarked that "the burden is placed on the hospital to make sure that the MP Plan works. There is very little education of MP Plan enrollees." After receiving rejected claims for failing to obtain prior authorization from PCMs before treating MP Plan patients, hospitals are instructing their emergency room staffs to comply with the MP Plan prior authorization requirements.

Some hospital officials would like to see improved communication channels between OPHC and the hospitals to be better informed about changes and developments in the Plan. The marketing representative for the MP Plan has been acting as a liaison between hospitals and OPHC in trying to resolve issues surrounding rejected claims. His efforts seem to have been helpful in improving relations between the state Medicaid office and the hospitals.

Hospital Outpatient Facilities as Case Managers: Some hospital outpatient facilities are interested in serving as case managers in the MP Plan and are exerting pressure on DMAHS through the governor's office to let them participate. OPHC, however, cited several reasons for not allowing outpatient facilities to act as case managers.

The first reason relates to specific policies governing reimbursement under the New Jersey DRG system for hospital inpatient services. Because there are financial risk associated with

participating in the MP Plan, a hospital outpatient department could sustain losses under the demonstration if it acted as a case manager. These losses though, would be allowable costs in the hospital's DRG rate base. Therefore, a hospital outpatient department would not be truly at risk as a case manager because it could recover losses through its total reimbursement base.

In addition to the above reason, the state is concerned that the use of residents as PCMs might result in a fragmented case management system, as patients may not see the same physician due to the residents' rotation schedules. And finally, Plan officials maintain that the inpatient capitation system would allow hospitals to game the MP Plan. Because case managers are not at direct financial risk for inpatient care, there would be an incentive for outpatient facilities to admit patients to the hospital to avoid risking any financial loss. The hospital would receive more money for treating an MP Plan patient on an inpatient basis than it would treating him or her on an ambulatory basis in the outpatient clinic.

CHAPTER FIVE

CONSUMER PERSPECTIVE

There are very few concrete details available regarding the program from a consumer perspective. As was mentioned earlier, there was no response to the Phase I patient satisfaction survey. There are no results available yet from the Phase II patient satisfaction telephone survey. Quality assurance and utilization review reports that might indicate the type of care that MP Plan patients are receiving and any changes in their use of the health care system have not been produced yet.

There has been no reaction to the MP Plan by consumer groups or welfare rights groups. Several groups located in areas where the Plan has a large enrollment were contacted. These groups were only slightly familiar with the Plan, if at all.

The following comments regarding consumer perspectives are drawn from conversations with providers and state Medicaid officials.

A. Incentives to Enroll in the MP Plan

Some providers maintain that Medicaid eligibles need to be given more incentives to enroll in the MP Plan. The primary selling point of the Plan is that it offers the opportunity for patients to receive greater continuity of care by having a personal physician to manage his or her care. The major incentives for enrollment include the

availability of the PCM on a 24-hour basis and guaranteed six month eligibility for Medicaid. Physicians and OPHC feel that these other two incentives may not be as influential as the promise of a personal physician. Many Medicaid patients perceive that they already have access to care on a 24-hour basis through the hospital emergency room. For those who are eligible for Medicaid on a continuous basis, the six month guaranteed eligibility does not carry any weight as an incentive.

The director of CamCare, a community health clinic in Camden, would like to offer additional services as part of the MP Plan benefit package, to make the Plan more attractive to Medicaid eligibles. He has proposed to offer transportation to and from the clinic, better choice of eyeglasses, and better pharmacy services. He emphasizes that the MP Plan lacks the added benefits that HMOs typically offer to offset the inconvenience of restricting the patient's choice of provider. CamCare also hopes to increase its attractiveness to the Medicaid population by opening an after-hours urgicenter that will treat patients who go to the emergency room for nonemergency treatment.

DMAHS officials have asked CamCare to submit a detailed outline of the additional benefits that it would like to provide, along with marketing materials that it intends to use. The state will not allow CamCare to offer any monetary benefits. They also want to make sure that the additional benefits are presented so that Medicaid eligibles understand that any extras offered are not part of the Medicaid benefits package.

B. Accessibility of the Case Manager

MP Plan case managers are required to be on-call 24 hours, whether this means having an answering service or arranging for an alternate physician to be available. It is difficult to assess whether case managers have been readily available because the prior authorization process has not been strictly adhered to by hospital emergency rooms and MP Plan enrollees. We are not able to judge whether MP Plan enrollees have better access to the health care system than they had under the fee-for-service Medicaid program.

C. Grievance Procedure

During Phase II the broker was primarily responsible for responding to and arbitrating enrollee grievances. It was not necessary for any of the grievances to be settled through the formal grievance procedure. (The formal grievance procedure is outlined in detail in the first year case study. Briefly, complaints that cannot be resolved by a broker liaison representative are referred to either the Medical Appropriateness Committee or the Community Liaison Committee. Cases can then be appealed to the broker's full board of directors, and ultimately to the Director of the Division of Medical Assistance and Health Services.)

According to the broker, most grievances were precipitated by the patient's misunderstanding of the requirements of the case management system. Many were upset that the prior authorization requirement prohibited them from receiving routine care in the hospital emergency

room and from referring themselves to doctors other than their PCM. The broker was able to resolve many of the grievances by educating the patient on how the case management system operates. In fact, the PSRO representative maintained that she spent much of her time engaged in patient education. The broker and OPHC staff reported that between 50 and 150 enrollees had voluntarily disenrolled from the Plan.

With the elimination of the brokers, the Plan staff is now handling enrollee grievances. Enrollees may report any complaints by calling the toll-free number printed on their Medicaid cards, or writing a letter to the OPHC. There is some concern that patient relations may suffer because OPHC has a limited staff. Enrollees may perceive the necessity of having to contact the state Medicaid office as an impersonal procedure. This may deter them from expressing dissatisfaction with the Plan. Patient relations might be enhanced if the Plan staff were more visible at the local level.

CHAPTER SIX

LESSONS LEARNED

The lessons learned thus far during the development and implementation of the New Jersey MP Plan are outlined below. A number of issues were raised during the course of the second year evaluation that cannot be addressed at this stage of the demonstration, given the information that is currently available. The last section of this chapter highlights some of these issues for future consideration

A. Administration

- * Effective administration of a demonstration program depends on the development of a management information system before the program becomes operational. This information system should be capable of producing timely reports regarding financial status and utilization trends.
- * PSROs did not prove to be effective in marketing and enrolling physicians in the MP Plan, in part because of their existing relationship with these physicians as a peer review group.
- * Careful consideration of the expected administrative needs of a program is required to avoid under-budgeting costs in this area.

B. Marketing and Enrollment in a Voluntary Program

- * Mass marketing techniques are not an effective means of selling the MP Plan to physicians. Successful physician marketing requires one-on-one contact between the physicians and Plan representatives.
- * CWAs are not appropriate sites for enrollment of Medicaid eligibles, because the majority of those eligible for the program are not likely to visit the CWA unless they have a special problem with their welfare payments.
- * A voluntary program needs an effective marketing strategy to make the program attractive to Medicaid eligibles and to physicians.

C. Political Support

- * The development of a successful program requires political support at the federal, state and local levels, as well as among providers and patients.

D. Case Management

- * Implementing a voluntary program presents special problems in obtaining the commitment of both physicians and patients to the case management concept, which is difficult even under mandatory programs.
- * Effective case management depends on the availability of timely reports for the purpose of tracking patient care and financial status.
- * Prior authorization procedures must be enforced if the case management system is to work effectively.

E. Competition

- * It is difficult to engender competition in the Medicaid program when most physicians have only a small number of Medicaid patients in their practice, and thus have very little reason to respond to the incentives of the Plan.

F. Risk Elements

- * A voluntary program presents the need for a trade-off in structuring physician risk. The MP Plan physicians risk waiver for the first year of participation proved to be an effective means of encouraging physicians to enroll in the Plan. At the same time, though, the effect of the risk waiver as an incentive for providing cost-effective care is uncertain, thus making it difficult to assess the impact of prepayment and capitated reimbursement on utilization.

G. Future Prospects

- * The administration of the statewide MP Plan is dependent upon increases in staff. The effective administration of the program is also dependent upon the availability of management information reports detailing Plan expenditures and utilization trends.
- * The rapid expansion of HMOs is one indication that the health care market is changing in New Jersey and that the environment is becoming more conducive to less traditional delivery systems and payment systems. This change seems to have spurred a heightened interest in the MP Plan among providers within the past few months,

although it is unlikely that it will have an immediate impact for the duration of the MP Plan.

H. Remaining Questions

- * What effect did the Plan's financial incentives have on utilization patterns? Are there any significant differences in utilization patterns of patients of PCMs who were at risk and patients of PCMs who were not at risk?
- * Are there any trends in the financial status of PCMs that would indicate a minimal number of enrollees necessary for the Plan to be profitable for an individual PCM?
- * Is there any indication that physicians with surpluses in their referral services fund during the first year of participation increased the number of Medicaid patients/MP Plan patients in their practices in the following year?
- * How did physicians with small Medicaid practices fare under the ambulatory capitation system? Could the system have been structured differently so as to make the risk more manageable, and therefore more attractive to these physicians?
- * What is the effect of having no down-side risk associated with the provision of inpatient services? Did the inpatient capitation system give the PCMs enough incentive to change practice patterns? Was there a decrease in hospital admissions among MP Plan patients compared to those patients in the traditional Medicaid program?
- * What is the effect of using different rate-setting methodologies during each phase of the demonstration?

APPENDIX A

Benefits Provided under the MP Plan

- o all physician services, including physicians services during hospitalization
- o hospital based emergency care for medical emergencies
- o hospital based outpatient clinic services
- o services at independent or free standing clinics and community health centers
- o podiatrist services
- o optometrists services and optical appliances
- o laboratory and radiological services
- o chiropractic services
- o home health services
- o psychologists services
- o inpatient hospital services
- o certified nurse midwife services
- o hearing aids, durable medical equipment, and medical supplies
- o prescription drugs

APPENDIX B

Inpatient Capitation -- An Example

The tables on the following pages present an example of how the inpatient services capitation system will work. As can be seen, there are five PCMs in this area. Over the year shown in the table, the total capitation allocations to all PCMs in the region amounted to \$83,160. Thus, each PCM is allocated \$396 per enrollee ($\$83,160 \div 210$) for an average capitation rate of \$33 per month per enrollee ($396 \div 12$). Total claims paid for inpatient hospitalization services on behalf of all enrollees of all PCMs in the region during the year amounted to \$77,160. Thus, there is a surplus in the inpatient services capitation fund at the regional level of \$6,000.

PCMs share in the savings across the whole region. Although not all individual PCM capitation accounts show a surplus (PCM 2, for example has a \$6,000 deficit in his/her individual account), all PCMs share in the savings. The total savings to be shared among PCMs is \$3,000 since the state will retain 50 percent of the total savings. Of the \$3,000, one half is distributed on the basis of panel size. Thus, PCM 1, with the largest panel would receive \$714 based on panel size ($100/210 \times \$1,500$) and PCMs 4 and 5 would receive \$36 each ($5/210 \times \$1,500$).

The other \$1,500 is distributed according to the savings experienced by each individual PCM. Since PCMs 2 and 4 experienced deficits

in their individual accounts, they will not receive any distribution from the second \$1,500. The other PCMs will receive distributions based on the amount of the savings in their accounts relative to the total savings attributable to them. The three PCMs with positive account balances (PCM 1, 3, and 5) realized a total savings of \$12,600. Thus PCMs 1 and 3 both receive \$714 ($\$6,000 / 12,600 \times \$1,500$) because both experienced \$6,000 in savings in their individual accounts, and PCM 5 receives \$71.

Therefore, PCMs with larger panels of MP Plan enrollees receive proportionately larger distributions of savings. PCM 2 for example, even though he/she experiences a loss across his/her panel would receive \$357 in distributions which is much larger than the distributions to either of the PCMs with smaller panels. Also PCMs which experience savings in their individual accounts would receive distributions greater than those of PCMs who do not. Thus PCM 3, with a surplus, receives a larger distribution than PCM 2, with a deficit, even though their panels are identical in size.

Also, it has been determined, in this example, that PCM 1 appropriately avoided two admissions that would have occurred but the patients were treated on an outpatient basis. During the year this PCM thus received two payments of \$200 each. PCM 4 also appropriately avoided one admission and received \$200.

Example of Distribution of Inpatient Services Fund Surplus

	<u>Number of Patients</u>	<u>Capitation Allocation</u>	<u>Inpatient Claims Paid</u>	<u>Net (Deficit)</u>
PCM1	100	\$39,600	\$33,600	\$6,000
PCM2	50	\$19,800	\$25,800	(\$6,000)
PCM3	50	\$19,800	\$13,800	\$6,000
PCM4	5	\$1,980	\$2,580	(\$600)
PCM5	5	\$1,980	\$1,380	\$600
Regional Area	210	\$83,160	\$77,160	\$6,000

	<u>Savings Share</u>			<u>Admits Avoided</u>		
	<u>(Panel Size)</u>	<u>(Acct Bal)</u>	<u>(Total)</u>	<u>Number</u>	<u>Amount</u>	<u>Total</u>
PCM1	\$714	\$714	\$1,428	2	\$400	\$1,828
PCM2	\$357	\$0	\$357	0	\$0	\$357
PCM3	\$357	\$714	\$1,071	0	\$0	\$1,071
PCM4	\$36	\$0	\$36	1	\$200	\$236
PCM5	\$36	\$71	\$107	0	\$0	\$107
Regional Area	\$1,500	\$1,499	\$2,999	3	\$600	\$3,599

Source: "Addendum II: Capitation Rates and Accounting Methodology," Paper prepared for DMAHS, March 5, 1984.

SOURCES

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² New Jersey Hospital Association, Hospital Statistics: Focus on New Jersey, April 1985.

³ Interstudy, National HMO Census, 1984, p. 38.

⁴ Ibid, p. 11.

⁵ "HMOs Eye Expansion, Sale in New Jersey", American Medical News, June 21, 1985, p.18.

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Evaluation of Medicaid Competition Demonstrations

Volume VIII

The Monroe County MediCap Program

by

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Preface

In September 1983, the Office of Research and Demonstrations in the Health Care Financing Administration awarded a contract to a consortium, headed by the Research Triangle Institute, to evaluate Medicaid competition demonstrations in six states: New York, Florida, Minnesota, Missouri, New Jersey, and California. An important component of the evaluation is the preparation of case studies in each of the participating states. These case studies have been the responsibility of the American Enterprise Institute, Lewin and Associates, Inc., and New Directions for Policy. Four case study reports for each demonstration will be issued annually or at a similar reasonable time interval.

This report represents the second case study of the Monroe County MediCap Project in Rochester, New York. It describes the evolution of the demonstration project and discusses the issues pertaining to the first 11 months of program operations (June 1985 through April 1986). The evaluation is based on site visits made in May and October 1985, and on extensive follow-up interviews that were conducted by telephone during the ensuing months.

The first case study report, published in June 1984, provided an overview of the demonstration site and the Monroe County Medicaid program. It also discussed issues related to the program's planning and development process. This second report summarizes some of this information, but readers should refer to the first year case study for more detail.

The authors wish to thank the many persons connected with the demonstration for their time and cooperation in helping us to complete this evaluation. In particular, we wish to acknowledge state and county officials, Mr. Barry Jesmer and the staff at MediCap, Inc., Mr. Richard Greene and the staff at Rochester Health Network, and the affiliated providers of RHN. We also would like to express appreciation to the following members of the research team for taking time to review and comment on earlier drafts of this report: Jack A. Meyer, John E. Paul, Fred Bryan, and Deborah A. Freund.

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CHAPTER ONE

OVERVIEW OF THE DEMONSTRATION AND ENVIRONMENT

A. Introduction

The MediCap program is a four-year demonstration being operated in Monroe County (Rochester), New York under a 1982 grant award from the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (DHHS). The objective of the program is to design and implement a Medicaid program that operates like the mainstream health care system, directing recipients to appropriate and necessary health care services within prescribed budget constraints.

The county's interest in developing the project stemmed from concerns about the growth in Medicaid expenditures and limited access to care for Medicaid recipients. The program underwent an extensive development process over a four-year period, beginning in 1981 when option papers for the demonstration project were prepared. After several delays, the final protocol for the first phase of the demonstration was approved by HCFA in May 1985. The demonstration became operational in June 1985.

This chapter includes a brief overview of the structure of the MediCap program and a description of the Monroe County health care environment. The evolution of MediCap will be discussed in Chapter II of this report. A more detailed description of the program, and issues surrounding its implementation, will be presented in Chapter III. Chapter IV will outline future directions for the demonstration and

Chapter V will offer conclusions about the project as it currently exists.

B. Overview of the Monroe County MediCap Program

The goal of the MediCap program is to enroll the entire Monroe County Medicaid population in prepaid, managed health care plans. Approximately 7.9 percent of the county's population is eligible for Medicaid. The demonstration is being designed and implemented in four phases. As mentioned above, the first phase of the demonstration is underway. Enrollment of the AFDC and Home Relief (HR) groups began in June 1985 and was completed in May 1986. The second phase will add the medically needy under age 65 (AFDC-MA and HR-MA) and children in foster family care. Medicaid recipients age 65 and older will join MediCap in its third phase. The mentally and physically impaired and the developmentally disabled who are Medicaid eligible will be enrolled in the final phase of the demonstration. MediCap officials project that all Medicaid eligibles will be enrolled in the program by January 1988. (See Table I for distribution of eligibles by category of assistance.)

The county created a separate, not-for-profit entity, MediCap, Inc., to administer and implement the MediCap program. Monroe County authorized the transfer of responsibility for the development and implementation of this prepaid, managed care Medicaid program from the county to this local corporation. MediCap, Inc. is essentially the "broker" for the project. It is responsible for policy development and planning, rate setting, provider contract management, enrollment of Medicaid eligibles, disbursement of capitation payments to

participating Health Maintenance Organizations (HMOs), and the operation of a quality assurance program. (See Appendix A for a breakdown of organizational roles under MediCap.)

Table I

Monroe County
Distribution of Eligibles by
Category of Assistance

Eligibility Category	Federal Fiscal Year 1984
AFDC	40,687
AFDC-MA	5,034
Foster Care	719
HR	12,546
HR-MA	2,945
Catastrophic	57
MA-Aged	5,160
MA-Blind	13
MA-Disabled	1,620
SSI-Aged	3,395
SSI-Disabled	5,224
SSI-Blind	102
Total	77,502

Source: MediCap Data Base, 1985.

MediCap officials outlined the following eight objectives for the demonstration:

- o Establish a prospective budget derived by capitation formula to compel public agencies, providers, and consumers to live within real health dollar limits;
- o Develop a community corporation (Monroe County MediCap Plan, Inc.) to assume administrative responsibilities negotiated with New York State agencies;
- o Establish a mix of existing and new provider units which affords all recipients access to the complete array of medical care settings;
- o Stimulate provider competition and cost containment by converting current "fee-for-service" and "cost-related" reimbursement to capitation payment;
- o On a phased basis, enroll the total Medicaid population in the Monroe County MediCap Plan, Inc., including adult categories and users of long term care services;
- o Establish procedures and incentives that motivate recipients to be "cost/quality conscious" in their selection of providers and their utilization of health care;
- o Maximize reliance upon control and quality assurance systems that are currently effective in the private medical sectors versus reliance on public regulation;
- o Develop and disseminate information and technologies useful to other counties in New York State and to other Medicaid jurisdictions.

At this time, MediCap, Inc. has contracted with one HMO, the Rochester Health Network (RHN), to provide care to the AFDC-HR population. It is in the process of negotiating contracts with two other HMOs in the area -- Genesee Valley Group Health Association (GVGHA) and Blue Choice. As this report was completed, GVGHA was on the verge of joining the MediCap program pending state approval of the

contract between MediCap, Inc. and the HMO. Blue Choice has said that it may come on board in 1987.

At this point it is worthwhile to give some background information on RHN because it plays such a major role in the demonstration as the only currently participating HMO. RHN has a long history of delivering and financing care for low-income persons. It began as the Neighborhood Health Centers of Monroe County, Inc. (NHCMC) in 1968. NHCMC was formed in response to an under-supply of primary care physicians serving Rochester's inner-city population. The group received a Section 330 grant for community health centers from the U.S. Public Health Service in 1971 that enabled them to provide ambulatory care at neighborhood health centers in several areas throughout the city. Over several years, NHCMC grew to include seven medical group facilities delivering care to low-income persons, and became known as the Rochester Health Network. In 1973, RHN officially became an HMO and expanded its services to employer groups in the Rochester area.

The HMO is essentially an administrative umbrella organization that contracts with thirteen affiliated provider groups. Its delivery system currently consists of nine health centers located throughout Greater Rochester, one IPA with approximately 700 private-practice physicians, and one Hospital/Medical Staff joint venture with 75 primary care physicians. RHN enrollees can choose to receive care from any provider group belonging to the network.

In 1975, Monroe County implemented a prepaid Medicaid program that was devised by RHN. This program enrolled approximately 10 percent of Medicaid eligibles with the vast majority of the enrollees signing up with RHN. Like the MediCap program, the county's original prepaid

Medicaid program was based on a primary care case management model. Participation in this program was voluntary though, unlike the mandatory enrollment required by the MediCap program. The IPA, called the Monroe Plan, was initially developed in 1975 to serve eligible Medicaid recipients enrolling in RHN, but membership was opened to employer groups and the privately-insured in 1979.

In addition to the provider groups listed above, three hospital outpatient departments (OPDs) joined RHN as providers of primary care and specialist services at the onset of the MediCap program. These OPDs do not deliver care on a prepaid basis to any of RHN's employer group members. (See Appendix B for a list of RHN affiliated providers.) RHN contracts with all hospitals in the area to provide inpatient services to both MediCap enrollees and its employer group members.

It is worth noting that all providers affiliated with RHN also deliver care on a fee-for-service basis. In fact, the majority of the health centers' patients are fee-for-service clients. In addition, many of the physicians participating in the Monroe Plan IPA also practice at RHN health centers.

Individuals enrolling in MediCap choose a physician that is associated with one of the provider groups to act as a case manager. This physician is then responsible for providing all primary care services, referring the enrollee to specialists and outside services as necessary, and authorizing hospitalization.

The MediCap benefit package for the AFDC-HR and Medically Needy eligibles includes the full range of services available under the traditional New York State Medicaid program; there is, however, a set

of services that will continue to be offered on a fee-for-service basis and which will not be included in the HMO capitation payment (see Appendix C). While the HMO is not at risk for benefits that are offered on a fee-for-service basis, the HMO is required to help the enrollee access and appropriately utilize such services.

The services that were excluded from the AFDC-HR MediCap benefit package are generally services that are required by individuals in other categories of Medicaid eligibility not included in this phase of the demonstration (e.g., SSI, disabled, and medically needy categories). The only two exceptions are dental services and methadone maintenance. During the planning process, advisory groups recommended that these two services be left out of the capitation payment.

According to a MediCap official, in the case of dental care it was perceived that including these services would involve a very different provider community and that organizing this group for purposes of delivering managed care would prove to be a difficult task. As for methadone maintenance, the delivery of this service requires a special license which only two providers in the county that have received. The advisory group believed that there would be very few, if any, benefits to be gained from introducing managed care in this area. The MediCap official reported, however, that MediCap is still considering ways in which they might introduce these services into the capitation in future phases of the project.

RHN receives a monthly capitation payment from MediCap for each enrollee. The payment rates are calculated for ten actuarial categories, taking into account age, sex, and category of assistance. MediCap derived the 1985 rates using Medicaid expenditure and

eligibility data for the base period July 1981 through June 1982 and trending them forward by an inflation factor. The 1986 rates were calculated by using a more recent set of federal fiscal year data -- October 1983 through September 1984. The state-to-MediCap rates are reduced by 5 percent to achieve the guaranteed savings to the state. RHN agreed in its contract with MediCap to accept premiums equal to 94 percent of capitated and trended costs. MediCap, Inc. retains the 1 percent difference to maintain a reserve fund with which to pay disputed claims that might arise in the program; any remaining balance is used to offset administrative and development expenses.

MediCap, Inc. is not responsible for determining physician risk arrangements within the HMO; each HMO decides internally how the financial risks will be shared. In RHN's case, each affiliated provider has signed a contract with RHN and receives a capitation payment to cover the costs of primary care services. Some providers also chose to take responsibility for paying consultant and ancillary services claims; they also therefore receive the portion of the capitation premium that covers consultant services. RHN pays the hospital inpatient claims for all of its affiliated providers.

RHN retains a percentage of the premium dollars that it receives from MediCap to cover administrative costs. In the initial contracts signed with the affiliated providers, RHN offered each provider two options with regard to this administrative withhold. Providers could choose to have 10 percent deducted from their capitation payments in the first year of the project, with this amount decreasing to 9 percent in 1986 and 8 percent in 1987 and 1988. Alternatively, they could agree to a 10 percent withhold in 1985, and the deduction in the

following years would be based on the results of an audit of 1985 program administrative costs. Providers choosing this option would not necessarily be guaranteed a lower percentage deduction; on the other hand though, it is possible that the percentage withhold might be lower than the 9 and 8 percent that they would commit to under the other option. According to one RHN administrator, the majority of the affiliated providers chose the first option with set deduction amounts.

An additional 80 cents per enrollee, per month of membership is deducted by RHN and deposited in a reinsurance fund. The money in this fund is used to pay 90 percent of the cost of inpatient care for enrollees whose hospital costs exceed \$35,000 in any given year. Affiliated providers are at risk for the cost of care that falls below this stop-loss limit. There are no reinsurance provisions for primary care or for ancillary and referral services; the provider is, therefore, at full risk for expenditures that exceed the capitation payment for these categories of care. The county's risk is effectively limited, as individual provider groups and RHN must exhaust their own resources before the county is liable for any cost overruns.

C. The Monroe County Health Care Environment

A brief review of the characteristics of the county's health care delivery system will help set the context for the implementation of the MediCap program. A more detailed overview can be found in the first year evaluation report.

Monroe County has had a long history of innovation in health care delivery, and has traditionally been at the forefront of New York's

efforts to contain rising health care costs. The county developed the earliest area-wide health planning system in the country in the 1930's; more recently it has actively encouraged the development of various alternative health plans.

There are currently four HMOs delivering care in Monroe County -- RHN, GVGHA, Preferred Care, and Blue Choice. Both RHN and GVGHA were established in 1973. GVGHA is a closed panel, group model HMO (i.e., GVGHA physicians may only practice with that particular HMO). It currently employs 51 physicians and has approximately 44,000 members.

Preferred Care, an IPA formed in 1979, experienced rapid growth during the past two years, more than doubling its enrollment from 49,000 members in June 1984 to 99,000 enrollees in May 1986. The IPA currently contracts with 900 physicians.

Historically, Blue Cross/Blue Shield dominated the private insurance market in the Rochester area. More recently, the share of the market that it enjoyed through its traditional indemnity plan has been eroded by the growth of alternative health plans. In response to Preferred Care's market success, Blue Cross/Blue Shield developed Blue Choice. Blue Choice quickly enrolled 48,000 members, the majority of these being employees that transferred from their old Blue Cross/Blue Shield plan to the IPA. As of May 1986 the plan had approximately 100,000 members. With the introduction of this new IPA in January 1985, the insurer estimates its current overall market share to be 65 percent.

There are an estimated 1600 physicians practicing in the Rochester area. A recent survey, conducted by MediCap, showed that 85 percent of Monroe County physicians participate in Medicaid; 62 percent of these

doctors report, however, that Medicaid patients comprise less than 5 percent of their practices. Providers cited burdensome paperwork and delayed payments as the principal reasons for their unwillingness to serve the Medicaid population.

It is important to note that the MediCap demonstration project is not Monroe County's first attempt to apply the case management and prepaid capitation concepts to the Medicaid program. As discussed earlier in the report, in 1975 the county began enrolling Medicaid recipients, on a voluntary basis, into a prepaid program devised by RHN. Both RHN and GVGHA contracted with the county to deliver services to those families eligible for Medicaid through the AFDC and Home Relief programs. In January 1985, approximately 5,200 Medicaid recipients were participating in the prepaid program. Almost all of these program participants were enrolled in RHN, divided evenly between its health centers and the Monroe Plan IPA. GVGHA had enrolled only a small number of persons (approximately 40). The existence of the original prepaid program is significant in that many of the providers participating in the MediCap program have, therefore, had previous exposure to delivering care to the Medicaid population under a prepaid, capitated financing system.

The following are the major differences between MediCap and the original prepaid Medicaid program:

- o The original prepaid program was voluntary, whereas enrollment in MediCap is mandatory;
- o Hospitals did not participate as affiliated providers in the original prepaid program;
- o MediCap capitation rates are broken out by actuarial categories, whereas providers received a standard rate for each enrollee in the old program;

- o The benefit package has remained the same, with the only major change being in the allowable number of annual outpatient psychiatric visits. The benefit is unlimited under the MediCap Plan, whereas the previous program imposed a limit of 20 visits per year;
- o RHN included a flat \$10,000 stop-loss limit under the original prepaid program for all services. Under the MediCap program, RHN has a \$35,000 stop-loss limit only on annual expenditures for inpatient care per enrollee;
- o The MediCap program includes a six-month eligibility guarantee and lock-in.

Monroe County hospitals continue to be reimbursed under the Hospital Experimental Program (HEP). HEP was developed by the Rochester Area Hospital Corporation (RAHC), a consortium of nine area hospitals, as an alternative to the statewide all-payer ratesetting system that was in effect from 1983 through 1985. The state legislature voted in July 1985 to discontinue the all-payer system and to replace it with a dual system. Hospitals are now reimbursed under the Medicare DRG-based prospective payment system, while Medicaid and third party payers continue to operate under the old system. The legislature has granted the Commissioner of Health the option of moving to an all-payer case-based system in 1988.

HEP's key feature is a revenue cap, calculated from the 1978 allowable cost-base and adjusted annually by an inflation trend factor. It is important to note that this revenue base reflects both community-based and hospital-specific costs, not prices or charges. HEP covers both inpatient and outpatient services, whereas the state all-payer reimbursement program covers inpatient services only.

Under this mandatory system, hospitals receive fixed weekly payments from the three participating insurers (Medicaid, Medicare, and Blue Cross) who estimate their percentage of the revenue cap from their

historical patient shares. These interim payments are adjusted at the end of the year to reflect actual experience. There is generally a lag time of at least one year before the final adjustments are determined and hospitals receive their final payments.

RHN and the other HMOs in the county pay actual claims submitted by each hospital, rather than making weekly payments to the hospitals. In the case of claims for MediCap patients, RHN reimburses the hospitals on the basis of the Medicaid per diem rate determined according to the methodology established under HEP. A specific rate is calculated for each hospital using the identical methodology.

A contract signed in late fall of 1985 extended the HEP program through 1986. This contract modifies HEP in two significant ways. First, it includes capital and interest costs in the calculation of the community revenue cap, although they are limited to one percent of the allowable cost base. The original calculations, on the other hand, only included operating costs. The second change is the inclusion of allowances for bad debt and charity care, medical education, movable equipment, administration, and research.

According to a RAHC official, the advantage of the HEP program over the state ratesetting system is that the revenue cap is calculated at the community level rather than at the individual hospital level. Because the total volume of services and capital costs for the entire community are taken into account, hospitals can effectively trade services and revenues. For example, one hospital might discontinue a particular service, and another hospital would add this service, without creating any adverse effects on the payment system. In this

way, HEP provides incentives for better integration of services on a community level.

CHAPTER TWO

EVOLUTION OF THE MEDICAP PROGRAM

A. Introduction

Concern over the escalating cost of providing medical care to Medicaid beneficiaries led Monroe County officials in the budget office and the Social Services department to begin developing alternative methods for financing this care. Planning efforts began in 1981 and options papers for a Medicaid demonstration project were prepared by the end of that year. When the Health Care Financing Administration (HCFA) issued a request for proposals under its new competition demonstration award program, county officials pressed the state of New York to seek federal funding for the continued development and implementation of their new program.

In April 1982, the state submitted the proposal for Monroe County's MediCap plan, and by the end of June it had received notification that the project would be funded. The Department of Health and Human Services awarded New York state a Section 1115 demonstration waiver, and HCFA granted four additional waivers to enable the MediCap plan to begin operation. Specifically, these waivers allowed the state to:

- 1) implement a Medicaid program on a local, non-statewide basis;
- 2) restrict recipients' freedom of choice of provider;
- 3) obtain maximum flexibility in health care provider reimbursement arrangements;

- 4) provide varying benefits to Medicaid beneficiaries.

Authorization of these federal waivers was received in May 1985, after final HCFA review and acceptance of the MediCap plan protocol.

B. State Authorization and Provider Contracting

There were a number of issues and obstacles that had to be resolved, however, before the MediCap Plan's final protocol was developed and the program became operational. The demonstration had to receive authorizing legislation from the state of New York, but the comprehensive and previously untested nature of the program's new health care delivery and financing mechanisms caused considerable concern in the state legislature. Because the proposed demonstration was to be mandatory for all Medicaid eligibles meeting program specifications, questions were raised about restricting patient freedom of choice under the case management model. State officials, therefore, wanted some guarantee of the number of physicians that would contract with the demonstration, stemming both from concerns over the program's viability as well as a desire to ensure that patients' choice of providers would not be unduly restricted.

According to MediCap officials, individual physicians and provider groups were reluctant to contract with the plan owing to concerns over reimbursement mechanisms, the requisites of case management, and the viability of the program model itself. MediCap planners were able to circumvent this problem by limiting their discussions with providers to the four area HMOs. Enabling legislation eventually was passed in June

1984, after representatives from these HMOs pledged participation in the MediCap program.

Yet, the MediCap Plan ultimately was unable to sign contracts with the four HMOs prior to implementation of the demonstration. Obstacles to contractual agreements that were cited by the provider groups included the detailed reporting requirements outlined in the protocol, a desire to do their own marketing to MediCap eligibles, unacceptable reimbursement rates, and the establishment of MediCap, Inc. as final arbiter in cases involving internal HMO/patient disputes. Time constraints for beginning enrollment also created other barriers to participation; one HMO was unable to enroll new patients until additional facilities were found, and another recently formed HMO was concentrating on private group enrollment and was not able to take on any Medicaid patients for another year.

The MediCap program came one step closer to beginning operation when the Rochester Health Network (RHN) agreed to contract with the demonstration. RHN's participation, however, was contingent on several factors. It proposed significant modifications in the reimbursement mechanisms which were subsequently adopted by MediCap, Inc., and which will be outlined later in this chapter. Moreover, because the demonstration was contracting with just one HMO, the state sought to ensure that patients' freedom of choice would not be too severely limited. RHN was, therefore, expected to negotiate affiliated provider agreements with all area hospitals. It also began bringing additional physicians into its IPA in an attempt to broaden its provider network.

The last major barrier to MediCap's implementation involved the coverage of family planning services. When family planning groups

learned that the MediCap program intended to capitate this part of the benefit package as well (thereby ensuring that these services would only be paid for when delivered by RHN's affiliated providers), they became concerned over the impending loss of their Medicaid patients. The groups lobbied the state to exempt family planning from the capitation premium, arguing that capping these services would constitute an infringement on patients' rights to confidentiality, and could also discourage younger patients from seeking assistance.

In response to these arguments, the state first proposed excluding family planning from the capitation entirely. RHN stood firm in its rejection of the proposal -- it was also ready to pull out of the demonstration entirely. Although the actual dollars involved were small, RHN and its providers strongly believed that the underlying principle was a crucial one; a plan that would allow unlimited self-referrals would undercut the very foundation of the case management system.

A compromise was finally reached when it was decided to include family planning in the capitation, and also to pay for these services through regular Medicaid fee-for-service channels if the patient chose to receive care through an outside agency. RHN is still somewhat skeptical over the efficacy of the compromise, however, because it undermines the primary care physician's role as gatekeeper by allowing patients to seek services without prior authorization. The potential also now exists for providers to refer patients outside the system while keeping the capitation payment -- thus leading to a situation in which providers receive "windfall" profits for services they do not deliver. State officials plan to monitor the situation closely and

take corrective action when necessary. Outside observers contend, however, that this will be a very difficult function to perform.

It is also interesting to note that once the state granted an exemption to family planning services, other special interest groups -- most notably alcoholism treatment programs -- began lobbying for special consideration as well. The state quickly recognized, as had RHN and its providers, that permitting an array of selected service exclusions would not only result in an unwieldy authorization process but would also threaten the case management model itself. All other petitions were therefore denied.

The MediCap plan itself underwent major modifications in the four years between its conception and ultimate implementation. As originally conceived, the demonstration would seek to promote competition among a broad cross-section of health care providers. MediCap planners stated that they sought to encourage widespread participation in the program by holding a series of meetings with any and all interested parties.

The option to contract with the demonstration was to have been open to any interested provider under the original program design. Individual physicians would have been able to form their own IPAs or group practices to help spread the risk associated with prepayment plans. This option generated little interest or response, and MediCap ultimately issued RFPs to the area HMOs. As mentioned previously, only RHN finally decided to participate in the demonstration, although discussions are still ongoing with two other HMOs.

There is some disagreement, however, over the willingness of MediCap planners to facilitate the contracting process with non-HMO

providers. Several hospital representatives expressed concern that they never received an RFP, that they were given very scanty information about the program, and that when more detailed material was finally made available, they did not have sufficient time to review and respond to the proposal before the deadline. These individuals also agree, however, that given the difficulties with program operations, it has been more practical to negotiate with MediCap as a single entity through RHN.

C. Proposed Payment Mechanisms

During this period of negotiation with providers, a variety of payment methodologies were considered. Originally, a single, full-risk model was developed that incorporated payment differentials to reflect differences in providers' utilization, risk sharing arrangements, number of patients, and non-comparable costs. Capitation rates were calculated and adjusted according to age, sex, and category of assistance. Additional payment rate variables included cost adjustments for hospitals' capital requirements and teaching programs, and measures of morbidity to "level" the differences in outlays for health care delivery across the Medicaid population.

The amount of risk the provider was willing to assume also affected its capitation rate, as well as the extent of its stop loss insurance coverage. Risk-sharing arrangements could be structured so that providers who were willing to accept greater responsibility for covering patient services would receive higher rates of payment, with reduced stop-loss withholds. Another possible option was to vary the

stop-loss limit by actuarial class; those providers serving a relatively healthier cross-section of patients would contract for lower payment rates, and have higher caps set to activate stop-loss coverage.

After the tentative agreement was reached to contract with the four area HMOs, however, MediCap, Inc. issued a revised protocol in the summer of 1984, which contained some rate setting modifications that reflected recent developments in the contracting process. Although the reimbursement methodology outlined in this version of the protocol was subsequently displaced by RHN's proposed system, it will be described briefly here both for illustrative purposes and because it may be resurrected when other categories of assistance and provider groups are phased into the program.

MediCap planners decided to develop a single, community-based target rate for each actuarial class, calculated from a base year period and trended forward by an inflation factor. These target rates represented the state-to-MediCap rate for each class, minus varying holdbacks for the stop-loss insurance plan and the contingency fund, as represented by the following equation:

$$\begin{aligned} &\text{Per Capita Revenue Available} = \\ &\text{State/MediCap Rate} - \text{Stop Loss Discount} - \text{Contingency Discount} \end{aligned}$$

The unlimited stop-loss insurance plan was designed to provide guaranteed coverage of all expenses incurred in excess of \$20,000 per MediCap enrollee. In addition to the revenue created for this fund by withholding a portion of each state-to-MediCap payment, MediCap officials planned to seek additional coverage either through purchasing

a commercial insurance plan, or by asking the state to provide aggregate stop-loss protection in the event of catastrophic overruns.

The contingency fund was to be created to assist those providers who may not have exceeded their stop-loss limit but who overspent their annual revenues due to adverse selection or non-comparable costs. This pool would have been funded solely by a 10 percent deduction from each capitation payment. Access to the pool would have been contingent on its liquidity and on the payment and risk levels the provider had negotiated during the bidding process.

Thus, in contracting with MediCap, the HMOs could only have negotiated greater or lesser capitation rates based on the amounts of their withholds and the amount of risk they were willing to assume. This also would have affected both the extent to which the provider could share in any profits realized by MediCap, Inc. (calculated annually), and the negotiated percentage of the annual trend factor used to determine capitation rate increases.

If an HMO chose to opt out of the contingency or stop-loss funds, its payment rates would increase, while its right to profits and a percentage of the trend factor would decrease proportionately. Similarly, if an HMO chose to receive a lesser rate of payment and contribute larger shares to the reinsurance pools, it would have first access to the stop-loss funds and would receive a larger percentage of the trend factor and any profits. If the HMO bids matched the target rates, it would receive 50 percent of the profits and the trend factor, with proportionately reduced access to the reinsurance funds. The relation between these variables is shown by the following table:

TABLE II

Bid Rate Variables Contained in Interim Protocol

<u>Incentive</u>	<u>Bid Target</u>	<u>Bid = Target</u>	<u>Bid Target</u>
Right to Profits *	100% to HMO	50% to HMO 50% to MediCap	100% to MediCap
Inflation *	100% of Trend	50% of Trend	Negotiated
Contingency Fund Access	First Rights	Reduced Rights	None
Stop Loss Insurance	First Rights	Reduced Rights	None

* The percentages used in this chart are for illustrative purposes only. Actual profit and inflation shares would have been adjusted according to the bid rate submitted by the provider.

MediCap was ultimately unable, however, to find any health care providers that were willing to participate in the demonstration under the guidelines established by the interim protocol. RHN eventually proposed a simplified payment mechanism in which it would receive all but 1 percent of the state-to-MediCap rates and would assume full financial risk for all covered services (see Chapter III). When the program began operation in June 1985, RHN was also the only HMO that had contracted with the plan. Although this effectively eliminated elements of competition from the program model, MediCap planners nonetheless decided to proceed with the project's implementation. Thus, the MediCap demonstration, which was originally conceived to promote competition among providers, evolved into a more basic experiment in managed care.

As program implementation continues, however, competition is emerging among RHN providers who are seeking to ensure their share of

the Medicaid market. Although these providers all operate under the RHN umbrella, they are in effect "competing" for consumers since MediCap enrollees are responsible for selecting their affiliated provider as well as their primary care case manager. Because this phenomenon is becoming more pronounced as program operation progresses, it will be examined more closely in the third year case study.

CHAPTER THREE

IMPLEMENTATION OF MEDICAP PHASE I: AFDC-HR POPULATIONS

A. Enrollment

MediCap began enrolling the AFDC-HR population in June 1985. Enrollment of this group of eligibles was completed in May 1986. MediCap reports that 40,473 individuals were enrolled in the program as of June 1986. The enrollment is broken down by RHN affiliated provider in the table below.

TABLE III

MediCap Enrollment

<u>Provider</u>	<u>Number of MediCap Enrollees</u>	<u>Percentage of Total Enrollment</u>
<u>Health Centers</u>		
Family Health	1386	3.4%
Genesee	5,057	12.5%
Jordan	8,354	20.6%
Northeast	1,800	4.4%
Oak Orchard	236	0.6%
Riverton	95	0.2%
Westside	4,936	12.2%
<u>IPA</u>		
Monroe Plan	7,142	17.6%
<u>Hospital/Medical Staff</u>		
Highland Health Care	1,967	4.9%
Rochester General	3,596	8.9%
Strong Memorial	5,029	12.5%
St. Mary's	875	2.1%
<u>Total Enrollment</u>	<u>40,473</u>	

Enrollment Process

Medicaid recipients can enroll in MediCap at any one of three centers located in county DSS offices. Any individual who is newly eligible for Medicaid, or is seeking recertification for Medicaid eligibility, is referred to a MediCap enrollment center by MCDSS income maintenance staff.

The potential enrollee views a brief slide show presentation describing the MediCap program. The person then meets with a MediCap counselor who explains the program in more detail, expanding on the managed care concept and outlining the MediCap participant's rights and responsibilities. MediCap currently has between five and seven part-time enrollment counselors staffing the three sites. During most of the enrollment period though, there were as many as seven counselors at each site.

After this orientation to the program, the enrollee is then asked to choose a physician that is associated with one of the RHN provider groups. A list of participating physicians is available, as well as a map of provider locations and brochures describing the different providers.

During the initial months of enrollment many providers expressed concern that the MediCap counselors responsible for enrolling Medicaid recipients in the program were not adequately trained. Providers cited the counselors' lack of familiarity with the various RHN providers, their facilities, and their services as causing problems.

According to a MediCap official, the supervisory staff at MediCap's office locations were trained over a six month period. The

Plan's counselors took part in a five day training session. The background on the history of the MediCap program and its features and policies were covered, as well as instruction on the MediCap computer system used for enrollment. As part of the training, the counselors made on-site visits to RHN facilities.

After negotiating a specific role with MediCap, RHN placed one of their own counselors at each enrollment site to assist the Medicaid recipient in the decision-making process. MediCap was initially reluctant to allow RHN to participate in the enrollment process because it was concerned that RHN representatives might inappropriately influence the enrollee's choice of affiliated provider and primary care physician. RHN, on the other hand, felt that directly involving its own personnel at the enrollment site would ensure smooth functioning of the process and would reduce the number of problems that had arisen because of a lack of information about the RHN system.

One RHN official described the RHN representative's role as analogous to the counseling function performed by the personnel department in employer group enrollment. The representative makes sure the individual enrollee knows as much about the RHN system as needed to make an informed choice of provider. The availability of the RHN representative at the point of enrollment is intended to contribute to the patient's education and ensure that the enrollee is assigned to an appropriate provider within the RHN system.

If a person is unable to select a physician case manager at the time of the enrollment interview, he or she is given 23 days to make a decision. After this period, MediCap sends a follow-up letter reminding the enrollee of the need to choose a physician case manager.

If there is still no response, MediCap makes the physician assignment for the enrollee based on geographic location, prior use by the enrollee, and any other pertinent information provided during the initial interview. A study conducted by MediCap showed that of the approximately 8600 new recipients that were enrolled in May 1986, one-third were assigned to a physician by MediCap as a result of the enrollees' failure to make their own choice of primary care doctor.

In an interim report to the governor and the state legislature in November 1985, MediCap noted that more than two-thirds of the enrollees chose their usual providers of care. Twenty-five percent of the enrollees did not have a health care provider prior to MediCap.

MediCap enrollees are given a six month eligibility extender at the time of enrollment. This means that even if they should lose Medicaid eligibility, they will continue to be enrolled in MediCap through the six month lock-in period. The purpose of this provision is two-fold. First, it is intended to ensure continuity of care for the Medicaid enrollee. Second, the provider is guaranteed to receive capitation payments for each enrollee for at least six months, thereby reducing exposure to financial risk. Individuals must remain enrolled in MediCap as long as they are eligible for Medicaid through the AFDC and HR categories of assistance.

Certain eligible individuals may be exempted from participation in the MediCap program if they meet one of the following criteria:

- o if the individual has been receiving services from a residential health care facility, a state hospital for the mentally disabled, a Veteran's Administration institution, an inpatient psychiatric facility for a period of more than 30 days, or is receiving care from a long-term home health care program;

- o if the individual lives more than 30 minutes travel time from a MediCap provider;
- o if the individual has been under the care of a physician not affiliated with RHN for more than one year and does not wish to change providers;
- o if the individual is already enrolled in an HMO through third-party insurance coverage available through a spouse or an employer;
- o if the individual has unique medical care needs that make enrollment in the MediCap program inappropriate. (This criteria would usually apply to a small number of individuals who have pre-existing medical conditions for which they already have a treatment plan for extensive medical care prior to enrollment in MediCap. These persons often should qualify for Medicaid through the SSI or disabled eligibility categories, but for programmatic reasons they obtain Medicaid eligibility through the AFDC and HR components of the program.)

At the onset of the MediCap program, RHN had approximately 3,000 Medicaid recipients enrolled in the existing prepaid Medicaid program. These persons received a letter informing them about the MediCap program and were given the option of staying with their current medical care provider or choosing another RHN affiliated provider. Anyone wishing to select a new provider was asked to contact an enrollment center. Those desiring to retain their current provider as their MediCap case manager were directed to return a response card indicating this preference.

Many of the recipients that were enrolled in MediCap through this rollover process appeared on the enrollment lists without a provider assignment. Although this problem caused much confusion among providers and recipients in the early months of program operations, it has since been resolved. It resulted from a misunderstanding on the part of RHN regarding the provider information (specifically, physician

license numbers) that MediCap required in order to add the original prepaid Medicaid recipients to the MediCap enrollment roster.

Disenrollment

There are only three situations that would allow a Medicaid eligible person to disenroll from the program. These are the following:

- o a person is found to be no longer eligible for MediCap enrollment because of a change in Medicaid classification to an ineligible category of assistance (i.e., SSI, Medically Needy), a change of residence to another county, or death;
- o a grievance or fair hearing process recommends disenrollment, or;
- o any one of the "good cause" criteria allowed for exemptions occurs (e.g., unique medical care needs).

In cases where an individual disenrolls from the program and then subsequently becomes eligible for MediCap again within 30 days of disenrollment, the person will be assigned to his previous provider. If it has been more than thirty days since disenrollment took place, the individual is allowed to choose a new provider if he wishes to do so.

Marketing

MediCap, Inc. has mailed informational packets to "non-MediCap" providers, community agencies, local schools, and the media to inform them about the program. In addition, the MediCap staff has offered informational sessions to hospitals, health centers, mental health

centers, county organizations, alcoholism providers, and human service organizations.

All AFDC and HR eligible individuals received an informational bulletin announcing the MediCap program in December 1984. The same handout is currently included in mail recertification appointment letters.

Each RHN affiliated provider has submitted brochures to MediCap describing their facilities. These brochures are available to Medicaid eligibles at the enrollment centers.

Issues and Problems

Several significant problems associated with the enrollment process have disrupted program operations. In October 1985, the Provider Subcommittee of the MediCap Board considered, but withdrew, a motion to slow, if not cease enrollment until problems were resolved. According to one RHN official, this suggestion generated discussion at high levels in the county, with the end result being that MediCap pledged to give more attention to provider concerns. The motion was, therefore, subsequently withdrawn pending the outcome of meetings between RHN and MediCap, and the results from a corrective plan which detailed the actions and timetable for resolving the problems.

One observer claimed there is a lack of communication between RHN and MediCap, which is critical because enrollment problems at the provider level must be communicated to MediCap via RHN. Another provider maintained that the substance of the issues is often lost in translation between the three parties. Several providers commented

that the staff at MediCap, Inc. has a "poor attitude" when it comes to resolving problems in a timely manner. MediCap officials, on the other hand, assert that enrollment problems have been addressed and resolved as they have arisen.

The major problems associated with the enrollment process are described below:

Disruption of Traditional Patient/Provider Relationships: There have been some cases where patients have been assigned to a provider other than their traditional provider. It is not clear whether this is the result of a lack of understanding on the part of enrollees at the point of enrollment, inaccuracies in the enrollment data entered into the computer systems, or the failure of enrollees to choose their own provider and, thus, having to be assigned by MediCap to a provider.

In an effort to keep disruption of traditional patient/provider relationships at a minimum, providers have devised an informal arrangement among themselves. The patient's traditional provider continues to deliver care to the patient, while the provider that is receiving the capitation payment for that particular patient agrees to send the money to the patient's traditional provider. In the meantime, a change provider request form is submitted to MediCap requesting the formal reassignment of the patient to his traditional provider.

According to several affiliated providers, the majority of change provider requests were rejected by MediCap. This led the providers to complain that a clear policy for changing providers had not yet been established. According to MediCap staff though, the policy is as follows: an enrollee can only change providers after the first 30 days

of enrollment 1) if they move within the county and their original provider is no longer easily accessible, 2) if there is a substantiated grievance, or 3) if there has been a data entry error in the enrollment process. For cases that do not fall into one of these categories, MediCap intends to adhere to the six month lock-in requirement.

Program officials maintain that this policy is designed to protect the provider from patients who may enroll for a short period of time, incur high medical costs, and then change providers. MediCap has indicated that some of the patients for whom change request forms had been submitted had been seen by the so-called "traditional" provider only once or twice. If this is indeed the case, providers may be attempting to protect their market share through the change-provider request process. MediCap also maintains that some providers are exhibiting an unwillingness to work within the constraints of a managed care system that requires them to direct patients to their assigned primary care physician, or risk financial liability for delivering care to patients that are not enrolled at their facility.

The providers, however, are calling for more flexibility in the lock-in requirement. Their primary concern is that the continuity of patient care not be disrupted. Although there has been a spirit of cooperation among the providers thus far regarding the exchange of capitation premiums, several providers indicated that this informal arrangement is not an acceptable long-run solution. They are also concerned about the financial risk involved as they continue to deliver care to beneficiaries who are not officially enrolled with them. RHN and MediCap, Inc. are in the process of negotiating possible modifications in the policy regarding changing providers.

Disappearing Enrollees: Another significant problem associated with the MediCap management information system is the disappearance of enrollees from the enrollment listing before the end of the six month lock-in period. According to MediCap officials, some county DSS staff were not aware that public assistance recipients remain enrolled in the MediCap program even if they lose public assistance eligibility before the six month Medicaid extender period ends.

In an effort to resolve this problem, MediCap, Inc. added status codes to the enrollment information to indicate whether an individual is currently eligible for Medicaid or in extender status. If the individual has been disenrolled, the code will indicate the reason for disenrollment.

Although some providers said that the codes have been helpful in clearing up some of the confusion, others maintain that enrollees are still disappearing from the enrollment tape without explanation. One health center administrator commented that his staff was having trouble distinguishing between those enrollees that have been legitimately dropped from the enrollment listing from those that have been mistakenly taken off the lists. Many providers are still skeptical about the accuracy of the enrollment information that they are receiving.

While some of the initial enrollment problems have been resolved, the end of the lock-in period for the first group of enrollees appears to have generated some new problems, according to several providers. When the first six-month lock-in period ended, providers noticed that a large number of enrollees disappeared from their enrollment list only to reappear the next month. Providers are not sure whether these

patients are still enrolled in MediCap or are back in the fee-for-service system during this interim period.

Dual Providers: Adult females (those 18 years old or over) may choose two physicians as their primary care case managers -- both an internist and an obstetrician/gynecologist. (A pregnant teenager also has the option of choosing an obstetrician/gynecologist.) In the initial months of enrollment, women were choosing physicians from different provider groups. This created a problem because RHN did not have any provisions for splitting the capitation payment between two providers. According to an RHN official, MediCap did not understand that the two physicians must be chosen from the same provider group. This situation was resolved by requiring adult female enrollees to select two physicians located in the same provider group so that it would not be necessary to split the capitation payment.

Patient Education: Some affiliated providers feel that patients are not adequately informed at the time of enrollment about the need to contact their primary care physician before seeking any outside health care services. This has resulted in confusion for patients when they find they cannot get needed services without the necessary authorization form. According to an RHN official, RHN is responsible for patient education at the point of enrollment, while the individual case manager and the affiliated provider groups are responsible for assisting enrollees in navigating their way through the RHN network.

Several of the providers had brochures printed that describe how to use their health center or outpatient department under the MediCap

program, hoping this would reduce some of the confusion. The providers intended for these brochures to be given out at the enrollment center after the patient completed the enrollment process. One provider claims that MediCap has decided not to hand out these pamphlets. According to MediCap officials, there was a period of time when, for unknown reasons, the provider brochures were not given to enrollees. When this became known, it was corrected and brochures are now handed out to all enrollees.

Two providers noted that they are making specific efforts to ensure that their MediCap patients understand how a case management system functions. These providers identify new enrollees and send them information about their particular facility and the MediCap program. Patients are also requested to call their provider to set up an initial screening visit. These visits are intended to introduce patients to their point of access to the health care system, as well as to allow the provider to assess the health status of individuals and identify medical conditions that may warrant particular attention.

Enrolling Newborns: The MediCap program did not have a system in place for linking newborns with a pediatrician case manager. One provider expressed concern that newborns who are not enrolled in MediCap prior to birth may experience delays in receiving necessary care. Without an assigned case manager, it is not clear who is responsible for authorizing specialty care for the infant and who assumes financial risk for care that is delivered. A MediCap staff member reported that a system has recently been devised in response to this problem whereby an unborn child will be assigned to a pediatrician prior to birth if

MediCap is notified of the expectant mother. Because this procedure was in the process of being implemented at the time that this report was being completed, the effectiveness of this approach in resolving the problem will need to be evaluated in next year's case study.

An additional problem involves the distribution of capitation payments for newborns. MediCap officials report they cannot receive capitation payments for newborns from the state until the infant is added to the state MMIS system. In order to do this, however, the parent must verify the birth by presenting the child's birth certificate at the income maintenance office. Once newborns are registered as Medicaid eligible and officially enrolled in MediCap, MediCap makes the appropriate retroactive payments to RHN. A MediCap representative reports, however, that there is usually a 3-6 month delay in payments to the HMO while the child is transferred from unborn status to newborn status.

B. Management Information Systems

Management information systems are operating at four different administrative levels in the MediCap demonstration project -- at the state level, the county/MediCap level, the HMO/RHN level, and the individual provider level. Each of these systems is to some extent interactive with the other systems.

At the state level, a new eligibility module was added to the state Welfare Management System (WMS). This module, called the Prepaid Capitation Premium (PCP) subsystem, identifies recipients as MediCap enrollees and records each enrollee's choice of HMO. The enrollment

information in this subsystem serves as the basis for the premium payments made to MediCap. The payments are generated through the existing fee-for-service Medicaid management information system.

At the county level, MediCap, Inc., with the assistance of a local management information systems consulting group, developed a local data system to meet specific reporting requirements unique to the MediCap program. The system interfaces with the state WMS and MMIS systems.

Currently, MediCap owns an IBM System/38 mini-computer. This machine serves as a communication controller and the central processor of the MediCap data system. Additional computing resources are purchased from Monroe County Data Processing (MCDP).

The enrollment and client tracking functions are currently done on the MediCap System/38. During the initial planning stages of MediCap, a system was devised that employed the MCDP staff and computer to do all enrollment processing. This reliance on external computing resources resulted in unnecessary delays for MediCap. MediCap, as an external user of MCDP resources, was "in line" with all other Monroe County departments, and was subject to regular "priority" delays. To deal with this, MediCap developed an in-house enrollment system. All reporting and inquiry functions are now performed by MediCap, Inc. using the MediCap computer. MediCap officials report that this allows the flexibility for change and enhancement, and improves access to the MediCap enrollment system when seeking information for service inquiries.

Individual provider/client encounters are tracked through MediCap's encounter system. Encounter-related data is forwarded to MediCap by the HMO and entered into the encounter system, which then

tracks encounters in a manner similar to the "fee-for-service" claims system.

MediCap also has developed a financial payment system. MediCap, Inc. recently requested and received authority from New York State to bill the fiscal agent directly. This will insure a simpler and more accurate billing and payment system.

In this early stage of program implementation, the state and MediCap systems have been primarily responsible for producing enrollment information and capitation payments. It was noted in the enrollment section of this report that the quality and timeliness of the enrollment data have been significant issues. MediCap sends two sets of computer tapes to RHN each month. One contains the enrollment information and the other is an account of capitation payments sent to RHN from MediCap. RHN adds the information to its own enrollment data files and then generates capitation payments to providers and issues RHN enrollment cards to MediCap beneficiaries based on this information.

Under a contractual agreement with MediCap, RHN is to receive the enrollment tape from MediCap prior to the beginning of the month. This is important because it enables the staff to process the enrollment information and deliver it to the providers at the beginning of the month, and also to send enrollment cards to new members. RHN representatives maintain, however, that during the initial months of the program they were not receiving the enrollment tape in time to accomplish these tasks. This situation seems to have improved, though, as the demonstration has progressed.

In addition to the issue of the timeliness of enrollment tapes, RHN maintains that it spends a considerable amount of time "cleaning up" the data that it receives from MediCap. This is apparently the result of inconsistencies in the information recorded on the two tapes. This problem also contributes to delays in the delivery of the monthly enrollment listings to affiliated providers.

RHN is in the process of upgrading its management information system to support the MediCap program. As part of this process, all data management responsibilities have been transferred to Network Design Group (NDG), a data systems consulting organization that is a wholly-owned subsidiary of RHN.

The new system was to be operational by early summer 1985, but the improvements were still not fully completed by early 1986. Consequently, RHN accumulated a backlog of unpaid claims during the first six months of program operations. It was not until January and February 1986 that they were able to begin paying claims on a regular basis. RHN has been advancing the hospitals lump sum payments in lieu of actual claims payments until the inpatient claims processing software becomes functional.

In conjunction with the claims processing delays, RHN was also late in supplying providers with timely reports of the balances in their capitation funds accounts. As a result, providers were limited in their ability to monitor their financial status under MediCap and to operate an effective case management system. In particular, they state that they have had difficulty tracking referrals without the help of regular claims payment reports. Although many of the providers keep internal records of referrals that have been made, they rely on the

claims-paid reports to indicate whether the patient actually followed through on the referral. They also cannot track whether a specialist submitted a claim and was paid out of the providers consultant services capitation fund.

According to a spokesperson for NDG, providers are currently receiving two monthly claims payment summary reports -- one for inpatient claims, and another for specialist and ancillary services. These claims payment reports are in addition to the enrollment and capitation payment reports that providers were receiving prior to the beginning of the year. The monthly enrollment report includes a listing of new enrollees, retroactive changes in enrollment, and a monthly enrollment summary. The capitation payments report gives a detailed account of the capitation payments received for enrollees in each actuarial category, including the allocation of premiums to the various capitation funds -- inpatient, primary care, consultant services, and other health care services. This report also indicates the impact of retroactive enrollment changes on the provider's premium revenue.

RHN also agreed in its contract with the affiliated providers to develop utilization reports. NDG is presently seeking input from providers to help design utilization reports that will best meet their needs. Primary care providers are required to submit encounter data on services delivered. In addition to processing this information so that MediCap can use it for quality assurance and utilization review purposes, RHN will also generate reports that give providers feedback based on the data. In the meantime though, providers are most

concerned about receiving accurate enrollment information and timely reports on the balances in their capitation fund accounts.

Two health centers have assumed the claims payment responsibilities for consultant and ancillary services as a result of RHN's inability to provide them with the necessary financial information on a timely basis. In January 1986, Jordan and Westside began contracting with RHN under Option II of the affiliated provider contract (described in the Risk Sharing section) because they hoped that this would increase the availability of financial information. They also report that the portion of the 9 percent RHN administrative deduction that they will now recover through this changeover should create substantial savings for their centers; these providers are now contracting with a local service bureau that charges them significantly less than the amount that RHN reimburses them for paying claims for consultant and ancillary services.

RHN has expressed concern over its ability to cover administrative expenses now that over one-half of the providers have chosen to take responsibility for claims processing and payment. In the first contract that was signed by an Option II provider, RHN agreed to pay the provider a specific dollar amount in compensation for performing the claims payment function. Now that the number of Option II providers has increased, RHN realizes that it cannot afford to continue reimbursing providers at this rate. The other Option II providers are holding RHN to the amount specified in the first contract, however, claiming that they are legally entitled to that rate under the "most favored nations" clause rule. RHN indicated that it will attempt to negotiate a lower administrative rebate fee with the providers.

According to one RHN official, the increase in the number of providers who are paying their own claims has created "a very serious administrative problem." In particular, many of the independent pharmacies are having difficulty getting paid for MediCap prescriptions -- it is not clear where they should be sending MediCap claims. This confusion has caused delays in payments, which is a critical issue for those independent pharmacies that operate on a very tight cash flow. The RHN official warned that the irritation of pharmacists could potentially have a negative effect on the pharmacists' interaction with MediCap beneficiaries. RHN is considering imposing a rule requiring all prescriptions to be billed through RHN as a means of resolving this issue.

One provider commented that RHN potentially can provide a more integrated and comprehensive management information service than an outside organization because the HMO would continue to pay inpatient claims as well as consultant claims. Nonetheless, those providers that have chosen Option II believe the need for timely information outweighs the as yet undemonstrated benefits of contracting with RHN for claims payment and information services.

Several providers have added on to their internal management information systems to accomodate the MediCap program and augment the information they are receiving from RHN. Strong Memorial Hospital, a teaching hospital associated with the University of Rochester, made the most significant improvements. The hospital installed a completely new management information system to support the delivery of managed care. The system features on-line enrollment information that is available throughout the medical center. It also generates monthly inpatient

utilization reports by provider and service categories for the purposes of internal utilization review. Another provider is in the process of transferring its paper records to a personal computer data base to create patient and provider utilization profiles.

The service bureau has enhanced its system to meet the needs of the clients that are participating in the MediCap program. It has developed a system for tracking referrals so that providers can pinpoint unauthorized visits and outstanding referrals. The bureau also generates a list that identifies MediCap patients whose medical expenses have exceeded the amount of their capitation premium. It is currently working on developing an on-line inquiry system which would allow providers to view information on individual patients -- such as claims paid and authorized referrals.

C. Rate Setting

The 1985 state-to-MediCap rates were calculated using claims data and eligibility information from state MMIS files and county files for the period July 1981 through June 1982. Individual eligibility information was linked to paid claims to determine expenditures within each category of assistance during this base period. Only claims for those services included in the MediCap HMO benefit package were selected for the data base. Claims for individuals not included in Phase I of the demonstration were deleted. After conducting several internal and external validations of the data base, MediCap officials

calculated a base capitation rate for each of the ten actuarial categories using the following formula:

$$\frac{\text{Total Expenditures for Persons in Class N}}{\text{Person Months of Eligibility in Class N}}$$

These base rates were then adjusted to reflect retroactive rate adjustments to hospitals, claims lag, and certain Medicaid services paid for by the county. In addition to these general adjustments, rates for relevant actuarial categories were corrected to take into account the more rigorous enforcement of State Child Health Assurance Program guidelines that is expected to take place under MediCap. (CHAP is New York's equivalent of the federally mandated EPSDT program.)

After applying these adjustments to the base rates, the rates were trended forward to the start-up date of the demonstration. MediCap officials used aggregate monthly expenditure data and a regression equation to calculate the inflation trend factor. (The regression equation is a single variable equation used to account for the impact of changes in case mix on increases in Medicaid expenditures during the trend period.) The final state-to-MediCap capitation payments were established after deducting 5 percent from each rate to account for the guaranteed savings to the state.

The 1986 state-to-MediCap rates received final approval from the state in late March 1986. Rather than apply an inflation trend factor to the 1985 rates, MediCap computed the 1986 rates using recently available claims and eligibility data from federal fiscal year 1984. This more current data is intended to yield rates that more accurately reflect actual Medicaid expenditures and utilization experience.

MediCap first submitted 1986 rates to the state Department of Health for approval in November 1985. In the period between November and March 1986, there was much discussion between the Department and MediCap, and several different sets of rates were proposed. RHN, with its technical advisors, also participated in the ratesetting process during this time. Approval of the rates was delayed when the Departments of Health and Social Services and MediCap could not reach a consensus on the appropriate methodology to use in determining the inflation trend factor.

State officials' primary concern was that MediCap employ a methodology that was consistent with the 1985 rate calculation methodology (as stipulated in the contract between the state and MediCap, Inc.). In keeping with this premise, the state insisted that MediCap apply the regression equation used in the 1985 ratesetting process to determine the inflation trend factor. MediCap officials maintain, however, that the regression equation no longer produces statistically significant results when applied to the 1984 data base. Further, MediCap staff asserts that rates derived from the regression equation are not only statistically inaccurate, they are also intuitively incorrect; the fact that the 1986 MediCap rates are 8 percent lower than actual 1985 fee-for-service Medicaid expenditures would seem to indicate that the new rates were not properly adjusted for inflation.

Responding to MediCap's concern over the statistical reliability of the regression equation, a spokesperson for the state commented that

the regression equation did not yield statistically significant results when applied to the original (1981-82) base rates. The state official felt that the statistical significance of the regression equation only became an issue with MediCap this year because they were not satisfied with its outcome (i.e., lower rates). The state asserts that the first year rates were too high, owing to the fact that they were based on 1981-82 data. The reason the 1986 rates are lower, according to a spokesperson at the Department of Health, is that prices have not increased enough to offset the effects of the significant reduction in hospitalization that has occurred in Monroe County during the past few years. This decrease in hospitalization is reflected in the more current expenditure data used to calculate the base rates.

The end result of the negotiations between the Department of Health and MediCap was a set of rates derived by using the regression equation to bring the 1984 base rates forward to the end of 1985. The rates were then trended forward through 1986 using CPI proxies and actual Medicaid rate changes, as well as fee schedule increases where appropriate. The second year rates are estimated to be between 11 and 14 percent lower than the first year rates. (See Table IV for a comparison of the 1985 state-to-MediCap rates to the 1986 rates.) This approximation is based on a weighted average of changes in the rates across all actuarial categories. The estimates vary depending on which particular set of eligibility information is used since the number of eligibles in each actuarial category varies at any given point in time. Although MediCap representatives partially attribute the decrease in the rates to what they believe was an inappropriate application of the regression equation, they also acknowledge that decreases in hospital

utilization and changes in the composition of the actuarial classes both of which are reflected in the more recent expenditure data) are also responsible for the drop in the rates.

The state decided that the new rates would not be retroactive to January 1986. Instead, they will be effective beginning with beneficiaries who enrolled in April 1986. This decision is essentially a goodwill gesture stemming from the state's desire to lessen the effect of the rate reductions on the providers. As the 1986 ratesetting process continued through the first of the year, RHN and its affiliated providers maintained that it was unfair to expect providers to be able to respond to the incentives of a prepaid financing system without knowing the amount of money they were receiving for services they were delivering. According to one RHN representative, the state's decision may have been influenced by the fact that at least one or two of the providers had indicated during the rate negotiation process that they would withdraw from the demonstration if the rates were made retroactive to January 1, 1986.

Another RHN administrator responded unfavorably to the outcome of the 1986 ratesetting process, stating that a 5 percent reduction in the rates would have been "much more palatable." RHN, as well as several of the affiliated providers, expressed concern that the capitation rates had been decreased in the absence of any definitive information regarding the financial performance of the providers under the first year rates. More than one affiliated provider commented that they feared the state would continue "ratcheting down" the rates in subsequent years and thereby remove the financial incentives for provider participation.

Table IV

New York State-to-MediCap Monthly Payment Rates (@ 95%)
1985 and 1986

<u>Actuarial Category</u>	<u>1985</u>	<u>1986</u>	<u>Percentage Change</u>
1	\$138.58	\$124.07	- 10%
2	42.31	34.63	- 18%
3	23.72	22.00	- 7%
4	20.73	27.53	+ 33%
5	78.47	82.94	+ 6%
6	49.37	39.26	- 20%
7	91.70	81.93	- 11%
8	138.02	86.58	- 37%
9	160.16	147.14	- 8%
10	117.86	113.28	- 4%

Actuarial Classes:

- (1) 1 year old males & females, AFDC/HR
- (2) 2-4 years, males & females, AFDC/HR
- (3) 5-15 years, males & females, AFDC/HR
- (4) 16-20 years, males, AFDC/HR
- (5) 16-20 years, females, AFDC/HR
- (6) 21-40 years, males, AFDC
- (7) 21-40 years, females, AFDC
- (8) 21-40 years, males, HR
- (9) 21-40 years, females, HR
- (10) 41-64 years, males & females, AFDC/HR

D. Risk Sharing Arrangements

When MediCap issued its interim protocol to the four area HMOs, it outlined a plan whereby MediCap, Inc. would withhold approximately 10 percent from the state-to-county rates to fund the two reinsurance pools. This would have resulted in net MediCap-to-provider capitation payments of 85 percent of standard Medicaid fee-for-service rates. RHN decided, however, that it preferred to receive a larger share of the money and assume a greater share of the risk. It therefore proposed that MediCap deduct only 1 percent from the state-to-county payments to cover disputed claims and defray internal administrative and development costs, and then forward the remainder of the capitation to RHN.

When MediCap agreed to RHN's offer, the reinsurance fund plans were shelved, and RHN was placed at full financial risk for all prepaid health care services. There is, however, some disagreement over the actual disposition of the 1 percent MediCap holdback. MediCap officials state that RHN and MediCap contractually agreed on the holdback to cover disputed claims and administration costs only -- providers would not have access to these funds. Yet, RHN maintains that this money was designated as "tap-able" by RHN if the capitation rates proved inadequate. (Moreover, when questioned about the 1 percent MediCap discount, RHN representatives stated they now believe this deduction was unnecessary since MediCap, Inc. receives "sufficient" funding from federal, state, and county agencies.)

RHN then developed a uniform Affiliated Provider Agreement which outlines the provisions and requirements for all RHN providers wishing to participate in the MediCap demonstration. Under the terms of this

agreement, providers subcontract with RHN to deliver care to eligible Medicaid beneficiaries on a capitated basis, and assume financial risk for all covered services. The document details the scope of affiliated providers' responsibilities in such areas as enrollment, benefits, quality assurance, utilization review, data systems, and program administration. It also contains three possible reimbursement arrangements the providers can choose from, which are described later in this section.

RHN deducts 9 percent (reduced from the 10 percent that was initially deducted in 1985) from each MediCap-to-RHN capitation payment to cover its own expenses for program administration, information systems reporting and coordination, account reconciliation, and claims payment. It then disburses a total monthly premium payment to each affiliated provider. The flow of the capitation payments is shown in the following chart:

BREAKDOWN OF PAYMENTS AND DEDUCTIONS THROUGHOUT SYSTEM:

	5% total savings deductions		Deduct 1% for administrative expenses		Deduct 9% for accounting, data systems, admin.	
HCFA/State County	_____	MediCap	_____	RHN	_____	Affiliated Provider
	\$\$\$		\$\$\$		\$\$\$	
<u>Rates:</u>		95%		94%		85%
		(Percent of Medicaid fee-for-service)				

The affiliated provider's monthly premium payments are comprised of four subcapitation allowance categories: 1) primary care; 2)

inpatient hospital services (including stop-loss insurance fund payments); 3) other health care services, and; 4) physician consultant services. The total monthly capitation premium amount paid to each provider represents the number of its enrollees in each actuarial class for that month, multiplied by the total provider premium amounts. The composition of the capitation payments, and the total provider premium amounts, are broken down by actuarial class in the following table:

TABLE V

Distribution of RHN-to-Provider Monthly Capitation Premiums:
By Subcomponent Categories for Each Actuarial Class
After 10% RHN Administrative Deduction (1985 Rates)

Class	Total Provider Premium	Inpatient Capitation Fund	Stop-Loss Fund	Other Services Capitation Fund	Consultant Capitation Fund	Primary Care Cap
1	\$123.47	\$77.86	\$0.80	\$7.44	\$1.56	\$35.81
2	37.73	6.28	0.80	4.37	4.36	21.92
3	21.13	2.05	0.80	2.29	5.59	10.40
4	18.47	4.73	0.80	3.12	1.84	7.98
5	69.92	30.26	0.80	9.04	3.07	26.75
6	43.99	15.06	0.80	8.60	5.53	14.00
7	81.70	33.97	0.80	11.90	5.09	29.94
8	122.96	64.56	0.80	14.20	17.63	25.79
9	142.70	64.07	0.80	18.17	18.09	41.57
10	105.01	47.25	0.80	19.61	8.36	28.99

Notes: 1) Column 1 represents actuarial class, defined by age, sex, and category of assistance (see Table III for class descriptions)
2) The terms "consultant" and "specialist" are interchangeable.

Source: RHN Affiliated Provider Agreement contract

Separate payment mechanisms have been created for each of the subcomponent categories. RHN developed three different claims administration and payment methodologies from which affiliated providers may choose. These methodologies were designed to afford providers some flexibility in the amount of financial risk and administrative responsibility they would assume under the terms of the demonstration. (See Appendix B for option selection by affiliated provider.) The following chart summarizes the three options as they pertain to the four subcapitation categories:

	<u>Option I</u>	<u>Option II</u>	<u>Option III</u>
PC:	Provider at full risk to deliver services. Submit encounter data for: state data base and RHN account settlement.	Provider at full risk to deliver services. Submit encounter data for: state data base.	Provider at full risk to deliver services. Submit encounter data for: state data base and RHN account settlement.
IHS:	Provider at risk for services. RHN pays all claims. Equal access to reinsurance pool.	Provider at risk for services. RHN pays all claims. Equal access to reinsurance pool.	Provider at risk for services. RHN pays all claims. Equal access to reinsurance pool.
OHS:	Provider at full risk for services. RHN administers and pays all claims.	Provider at full risk for services. Provider administers and pays all claims.	Provider at full risk for services. RHN administers and pays all claims.
CS:	Provider at full financial risk. Consultants are paid, and the provider account is charged the UCR rate. 100% recovery of any surpluses. RHN administers and pays all claims.	Provider at full financial risk. Responsible for rate negotiation, and the administration and payment of claims.	Risk shared with RHN. Consultants are paid, and RHN is at risk for UCR rates; provider account debited, and provider at risk for Medicaid allowable charges. Reduced access to surpluses. RHN administers and pays claims.

Note: PC = primary care; IHS = inpatient hospital services; OHS = other health services; CS = consultant services.

Primary Care Services

All affiliated providers are placed at full financial risk to deliver primary care services within the ceiling set by the monthly subcapitation payments, regardless of the option they have chosen. New York state officials felt it important to continue building the Medicaid data base to analyze MediCap utilization in Monroe County and compare this across the state with other pre-paid plans. RHN therefore requires all affiliated providers to submit priced encounter data on standard Medicaid forms. For Option II providers this is merely a formality, but for Option I and III providers this information is used to calculate primary care account balances as a part of the year-end settlement process which will be described later in this section.

Inpatient Hospital Services

RHN pays inpatient hospital claims for all affiliated providers regardless of the payment option that they choose. It has established an inpatient account for each of these providers, funded by the inpatient capitation subcomponent of the total monthly premium amount. The provider submits approved claims to RHN which then pays the hospital for each enrollee's inpatient days at the hospital's own Medicaid per diem rate as established under HEP. RHN then deducts from the affiliated provider's inpatient account an amount equal to the estimated average community per diem rate for each inpatient hospital day that is paid at the HEP rate. (This provision was incorporated so

as not to discourage higher-cost hospitals from delivering care to MediCap enrollees, nor providers from referring patients to these facilities.) Once a final average community per diem rate can be calculated at year-end, RHN will retroactively adjust and settle the affiliated provider's account balance.

RHN deducts \$.80 per enrollee per member month from each provider premium and pools it into its MediCap Reinsurance Fund, which is administered by RHN. Proceeds from this fund are used to reimburse affiliated providers for inpatient costs in excess of \$35,000 that are incurred by a MediCap enrollee during any consecutive twelve-month period. Reimbursement from this fund is calculated by multiplying an enrollee's actual inpatient hospital days by the estimated average community per diem rate. When these costs exceed \$35,000, the affiliated provider will be reimbursed at a rate of 90 percent for any additional inpatient claims that are incurred during the twelve-month period. No professional fees or other medical costs associated with the stay are covered by the reinsurance fund.

To facilitate the fund's operation, the Affiliated Provider Agreement stipulates that the physician may only admit enrollees to hospitals that have contracted with RHN to accept deferred payment when fund resources are not sufficient to cover an inpatient stay. The requirement is waived, however, in cases of emergency care or when the contracting hospitals are unable to provide the needed services.

Other Health Services

Under Options I and III, payment of claims for other, non-primary care services (e.g., hospital outpatient, emergency room, drugs, transportation) are processed and paid by RHN on behalf of the affiliated provider. When these services are performed by a hospital, the claims are paid at 90 percent of the hospital's outpatient rates in effect at that time. Providers that choose Option II process and pay claims for all non-primary care services directly. All three options place the affiliated providers at full financial risk to deliver these services within the limits set by the monthly subcapitation payments.

Consultant Services

The primary reason for developing the three different payment mechanisms was to offer providers a wider choice in administering and paying consultant (specialist) claims. Option II was created for providers who are equipped to administer claims and to negotiate their own payment rates with consultants. Under the terms of this option, providers are also responsible for arranging specialist referral agreements, and adjudicating and paying all claims. The affiliated provider assumes all financial liability for these services; it must absorb any losses that are incurred, but it may also retain all surpluses that are accrued. RHN reimburses these providers a negotiated amount of the 9 percent withhold in exchange for their administration of these claims.

Options I and III were developed for providers who did not wish to undertake major responsibility for administering consultant contracts and payment of claims. Under both of these options, RHN segregates a consultant "reserve fund" from the provider's total monthly premium amount and charges all approved claims against this account. RHN pays signed consultants 80 percent of the then-prevailing RHN fee schedule (UCR charges), and pays unsigned consultants at the then-prevailing Medicaid fee-for-service rates. (These Medicaid allowable charges are referred to in New York as MMIS rates or charges.)

Under Option I, however, the affiliated provider's consultant account is charged the actual dollar amount that RHN pays to the specialist, and the provider is obligated to cover any deficits that are incurred. Under Option III, the account is charged the lower Medicaid fee schedule rate, and the provider is only responsible for covering total MMIS charges -- RHN is liable for any deficits that exceed the sum of the difference between UCR charges and MMIS rates.

Option III was created for those providers who were concerned about running a deficit in their consultant accounts (since MediCap capitation rates were calculated at 95 percent of MMIS but consultants are paid UCR rates). To compensate RHN for assuming a share of the risk for these services, however, providers that choose this option have reduced rights to account surpluses, whereas Option I providers receive 100 percent of any profits.

The 20 percent withhold for signed consultants' claims will be allocated at year-end, depending upon the status of these accounts and the provisions of the chosen option plan. The withholds are placed into a separate interest bearing account until the year-end settlement

process when they are merged with the provider's reserve fund to determine a net consultant balance (see next section).

Annual Account Settlement

At year-end, RHN will calculate a net claims accounts balance for each affiliated provider, in order to recover any deficits owed RHN or to distribute any surpluses owed the provider. The first step in the settlement process will be to calculate the final balance in the provider's inpatient hospital account. This will be accomplished by adding the sum total of monthly subcapitation payments, and then deducting hospital payments (after adjusting charges by the final average community per diem rate differential).

For groups choosing Option II, RHN will either pay the provider 100 percent of the account balance if it is positive, or be reimbursed 100 percent of any account deficits. This will complete the entire settlement process. For Option I and III providers, however, the inpatient account balance (either positive or negative) will be carried forward and applied in accordance with the procedures outlined below.

The next step in the Options I and III settlement process will be to calculate the primary care services account balance. This is accomplished by summing the monthly subcapitation payments and then subtracting the primary care charges that were originally reported through the affiliated provider's priced encounter data. The balance of this account is then carried forward as well. The same process is followed to determine the balance in the provider's Other Health Services account.

RHN will then calculate the provider's consultant account balance by summing the monthly subcapitation payments (including the 20 percent withholds held in reserve, plus interest) and deducting the charges against the account (net of the 20 percent withholds) that were made by RHN. For Option I providers, these charges represent actual RHN disbursements to consultants. For Option III providers, however, these charges were originally reduced to reflect Medicaid fee-for-service rates. Thus, the difference between actual charges and RHN payments automatically generates a "deficit payment" amount which will be adjusted for at the end of the settlement process.

Once the positive or negative balance in this account is calculated, it is then carried forward and used to determine a final net claims accounts balance, according to the following formula:

Hospital Inpatient Account Balance	(plus or minus)
Primary Care Account Balance	(plus or minus)
Other Services Account Balance	(plus or minus)
<u>Consultant Services Account Balance</u>	(plus or minus)
Net Balance of Claims Accounts	(plus or minus)
(Net Provider Surplus or Loss)	

It is at this point in the settlement process that there is a divergence in the way in which the account balances are handled. Under Option I, RHN will use the net surplus amount to repay consultants the 20 percent withhold that was originally deducted from payment, and the affiliated provider will recover 100 percent of any remaining surpluses. The affiliated provider is also liable for any deficits that are incurred and must promptly reimburse RHN for their full amount.

Under Option III, any net provider surplus will first be used to reimburse RHN for its "deficit payments" to specialists (i.e., the difference between MMIS account charges and actual UCR payments). If a surplus still exists in the account, consultants will be repaid the full amount of their 20 percent withholds. Any remaining surplus will be divided between RHN and the affiliated provider: RHN will retain 20 percent of the balance, and the provider will receive the remaining 80 percent.

It is important to note that the Option III settlement process entitles RHN to 20 percent of the affiliated provider's net surplus amount. This means that even if the consultant account balance is negative, when there are surpluses in any of the other three accounts that combine to create an overall provider surplus balance, the provider will receive only 80 percent of the savings. Moreover, RHN staff have stated that running a deficit in the consultant account is not uncommon, but that substantial surpluses are usually generated through the case management of inpatient hospital services. Providers are, therefore, paying a potentially high price for the risk-sharing arrangement adopted under this option. As stated previously, however, if there is a net provider deficit balance, the provider will only be held liable for total MMIS charges, and RHN will be at risk for the remainder.

E. Quality Assurance and Utilization Review

The New York Department of Social Services (DSS) is responsible both for monitoring and assessing MediCap operations, and for conducting fair hearing processes. The state Department of Health, in conjunction with the DSS, maintains statutory and regulatory functions for quality of care enforcement. In addition, the MediCap program requires that all participating providers have approved internal utilization review (UR) and quality assurance (QA) systems in place.

To ensure that these systems are functioning effectively, providers must submit monthly encounter data to MediCap, Inc., which it uses to generate reports that track both QA indicators and utilization levels, and that monitor trends for comparison with community norms. MediCap verifies provider encounter data by reviewing the adequacy of medical records that are randomly selected each month.

MediCap created a quality assurance committee that is composed of RHN providers, the RHN medical director, one MediCap board member as a liason, MediCap's medical consultant, and its quality assurance coordinator. The Committee's primary responsibilities are to review each provider's QA program and to assess and make needed recommendations on QA programs based on encounter data, grievance information, and the results of client surveys, focused studies, and medical record audits conducted by RHN and MediCap. Client satisfaction surveys and provider QA program review have already been undertaken, but the encounter data, audit review, and focused study activities will not become fully operational until the fall of 1986.

Client Satisfaction Surveys

Client satisfaction surveys are a key component of MediCap's efforts to ensure appropriate quality of care. The first of these surveys was conducted in the spring of 1984 when 495 AFDC heads-of-household were interviewed by MediCap researchers. The study investigated a variety of subjects, including:

- o the reasons behind clients' health care provider selection
- o reactions to proposed program modifications under MediCap
- o clients' perceived health care needs
- o satisfaction with their current health care provider
- o familiarity with the community health care system
- o client utilization profiles and anticipated changes under MediCap

The results from this study are being kept on file for comparison with future client satisfaction surveys that MediCap plans to administer if it can secure research funding.

MediCap counselors are currently asking an additional 2600 AFDC and HR beneficiaries to fill out questionnaires investigating enrollees' "health beliefs" and attitudes toward health care, their ability to recognize symptoms, and their sources of advice and treatment for health care problems. The information from this survey will be used to better understand enrollee attitudes toward health and health care and, thus, to improve utilization of health care services.

When the demonstration has completed enrollment of the entire AFDC and HR populations in mid-1986, a third survey will be administered to evaluate clients' opinions on quality of care, access to care,

"humaneness" of providers, and general satisfaction. The results of this survey will be compared with those of the 1984 study, and MediCap staff will make any needed recommendations for program improvement. MediCap will conduct a follow-up survey after the first full year of implementation to evaluate clients' experience and level of satisfaction under a managed care program.

RHN's Quality Assurance and Utilization Review Programs

Affiliated providers will be required to comply with RHN's quality assurance program. This comprehensive program delineates provider responsibilities in a wide range of areas including personal standards, service accessibility, patient rights, hospital admissions, emergency care, hospital utilization, specialist services, and general administration.

The affiliated provider must offer 24-hour telephone coverage to advise enrollees of the procedures for emergency and urgent care. All services must be provided as medically necessary on a prescribed, timely basis. The patient has the right to request complete information concerning diagnosis and treatment. All pertinent information should also be made available to enable the patient to give informed consent prior to non-emergency procedures. The patient retains the right to refuse treatment to the extent that is legally permissible.

Affiliated providers must cooperate with RHN's medical director, who heads the quality assurance program. Providers are required to furnish the data necessary to enable the director to produce regular

reports on current hospital admissions, prospective admissions, hospital days, consultant services, and enrollees that exceed a predetermined number of services or dollar outlays.

RHN has also established a medical director's group composed of the medical directors from each participating affiliated provider organization. This group, in conjunction with RHN's medical director, investigates and takes corrective action on any problem cases that arise.

All non-emergency hospital admissions must be authorized by RHN upon application of the primary care physician. The affiliated provider must submit all emergency hospital admissions to RHN for approval within 24 hours of the admission. Emergency admissions are authorized for a three-day period; subsequent transfers to an affiliated provider physician, if necessary, will be made after appropriate case evaluation. Pre-admission testing must be performed whenever feasible, and all hospital stays are monitored daily. The utilization review nurse and RHN's medical director both work with the hospital utilization coordinator to monitor each admission and hospital stay. Affiliated providers are responsible for discharge planning.

RHN reviews all hospital admissions and will deny payment for any inpatient treatment that could have been performed on an outpatient basis. Retrospective review activities also assess length of stay, specialist services, discharge planning, and patient follow-up care. RHN also tracks specialists' costs and volume of services for each affiliated provider; it will then identify any unusual costs and aberrant trends in utilization and take immediate corrective action when necessary.

RHN's Primary Care Physicians Committee will perform peer review of physician referral patterns, giving special emphasis to emergency care. It will also review ambulatory care on a regular basis, evaluating the frequency of visits and periodic examinations, specialist referrals, use of laboratory and radiological procedures, and the costs and effectiveness of health care delivery.

Affiliated Providers QA and UR Systems

In addition to meeting RHN's quality assurance and utilization review requirements, most affiliated providers have implemented their own internal systems as well. Many are also working to develop more effective and comprehensive methods for monitoring quality of care and utilization of the health care system.

The extent of internal utilization review systems varies widely by provider. In some facilities they exist in rudimentary form, with the medical director simply monitoring length of stay, inpatient admissions, and a random sampling of outpatient claims. Other providers have much more comprehensive systems that incorporate pre-admission certification, concurrent and retrospective review, and computer-generated reports for all inpatient services, sorted by physician and service category. Some providers are also creating physician and patient profiles to identify, through periodic review, any high-cost outliers and under or overutilizers of the system.

Most affiliated providers require prior authorization of services to limit self-referrals and unnecessary care. Billing personnel, who verify the patient's enrollment status and adjudicate claims before

submitting them for payment, will deny coverage for any unauthorized claims.

Providers also monitor referral services as part of their QA efforts, to ensure that proper follow-up care was obtained by each MediCap patient. Some of the providers that contracted with RHN to pay specialist claims (Options I and III) stated that they are unable to track referrals, however, because they are not receiving claims payment reports from RHN.

Many of the affiliated providers do not have established procedures for handling inappropriate use of emergency room services, but they are currently being developed and will be included in newly-created UR programs. Some providers stated that it is difficult to get ER staff to refuse services to non-emergency patients because hospital emergency departments are required by law to provide services to any person seeking care. These affiliated providers, therefore, can only review claims on a retrospective basis, identify non-emergency cases, and then contact the patient to explain the protocol for routine care. (Providers stated that the majority of ER cases often involve males with alcohol and drug problems, however, which makes case management extremely difficult.)

In cases of repeated non-compliance, the affiliated provider notifies MediCap and RHN. A referral should be made to Monroe County Department of Social Services Adult Protective Service if a person is non-compliant. RHN can recommend to MediCap that a patient be re-assigned to another provider but only MediCap has the final authority to perform this function.

Most affiliated providers incorporate chart review as part of their basic QA program. Several have created in-house quality assurance committees that monitor QA activities and take corrective action when any problems are identified. QA personnel also seek to identify abnormal practice patterns and under/overutilization, as well as monitor the appropriateness of services rendered. One provider group's QA committee is also designing uniform criteria for physician office records. In addition, several of the affiliated providers are currently developing protocols for standards of care as part of their QA and UR efforts. Protocols are being formulated for services in a variety of areas ranging from OB/GYN and childhood immunization to adult medicine.

F. Grievance Procedures

Each affiliated provider is required under the provisions of the demonstration to have MediCap-approved internal grievance procedures intact to mediate disputes that arise between a MediCap enrollee and the contracting provider or one of its physicians. If the grievance cannot be resolved at this level, or if the enrollee is dissatisfied with the outcome, RHN's medical director will review the case and attempt to make a settlement.

When a resolution cannot be obtained, or when questions of medical policy exist, the case will be referred to the medical director's group for arbitration. A copy of the grievance, the group's findings, and the action taken will then be sent to MediCap, Inc. In cases where a mutually satisfactory settlement cannot be reached through this process, RHN will forward the unresolved grievance to MediCap.

If MediCap staff are unable to resolve the issue informally between the disputing parties, an appeal will then be made to MediCap, Inc. for judgement on the grievance. After review by the members of MediCap's community-based grievance committee, a decision will be issued that is final and binding on the provider. The enrollee, however, is free to appeal the decision and request a fair hearing from the state Department of Social Services -- the final arbiter of all grievances.

The grievance committee also processes all disputes that arise between MediCap, Inc. and its providers and clients over procedures and policies. In all cases, disputes must be settled within 45 days after the initial receipt of complaint. The grievance committee has not had

to adjudicate any grievances in the first nine months of program operation. The Rochester Health Network reports, however, that it has had to settle eleven minor grievance cases that were received from opticians and pharmacists seeking payment, and from enrollees requesting provider transfers or disputing accepted case management procedures.

CHAPTER FOUR

FUTURE DEVELOPMENTS

A. Participation by Other Providers

As stated previously, MediCap planners originally sought to contract with the four major HMOs in Monroe County. Although RHN was the only provider that initially chose to participate in the demonstration, it was expected that at least two of the three remaining HMOs -- Genesee Valley Group Health Association and Blue Choice -- would contract with MediCap within the first six months of program operation. But, no additional HMOs have joined the demonstration at this time. GVGHA is, however, finally on the verge of signing a contract with MediCap, and expects to begin enrollment of program eligibles in the fall of 1986.

There were a number of issues and obstacles that had to be resolved before GVGHA could join the MediCap program. GVGHA is a closed panel HMO that delivers care to over 44,700 patients through its three area health centers. Only 1,200 of its clients are Medicaid beneficiaries, and of these, 750 are AFDC/HR recipients. GVGHA had expressed concern over enrolling additional prepaid Medicaid patients with whom it had no previous experience. It proposed, therefore, that enrollment be limited to rollovers from their current Medicaid membership. Spokespersons for GVGHA also maintained that it would be necessary to secure new or expanded facilities before they could accommodate any significant increase in the number of patients that

their health centers serve.

MediCap planners eventually agreed to limit enrollment to this small number of rollovers if GVGHA would negotiate re-opening enrollment to new beneficiaries several months after program implementation. GVGHA has also just begun construction of a new addition to the Wilson health center which, because of its location and accessibility, will probably be the main facility that GVGHA's MediCap patients choose to receive care; the expansion of Wilson is expected to be completed in the summer of 1987.

Another issue that delayed the entry of GVGHA into the demonstration was the HMO's concern over the extensive and detailed encounter data requirements outlined in the MediCap protocol. In the past, all MIS functions were performed for GVGHA by Blue Cross/Blue Shield, and many of the data systems were limited in the kinds of information they could provide. GVGHA instituted its own in-house computer system in January 1985, however, and its staff now feels confident they have developed the software capability necessary to comply with the demonstration's data requirements.

When these issues were resolved, and all that remained was for GVGHA to review the final 1986 rates, it was predicted that enrollment would start the beginning of the year. Yet, because there were rate negotiation problems between the state and MediCap, contracting was delayed. Once the 1986 rates were issued, MediCap and GVGHA quickly reached an agreement and submitted a contract to the state (in May 1986) for review and approval. A spokesperson for GVGHA says no word has come yet from the state but, once the contract is approved, both MediCap and GVGHA will sign, and enrollment of program eligibles should

begin the following month.

GVGHA's responsibilities under the demonstration are very similar to those outlined for RHN. GVGHA has also agreed to the same payment system and the 1 percent withhold to cover MediCap's administrative expenses. The structure of the HMO is such, however, that it will not be able to pass off the risk to its providers as RHN has; GVGHA itself will be at full risk to deliver all covered services under the capitation rates.

Blue Choice was formed by Blue Cross/Blue Shield in response to the rapid growth of Preferred Care, a recently formed IPA. BC/BS saw its market share eroding (from 85 percent to 70 percent) as an increasing number of employees selected the IPA plan over the traditional Blue Cross indemnity plan. Moreover, many physicians became concerned when they began losing patients to Preferred Care providers and they therefore pressured BC/BS to develop and offer an IPA of its own.

The Blues responded by creating Blue Choice, an IPA that began operation in January 1985. It enrolled 50,000 members from its employer groups, and signed on 1,100 physicians during its initial start-up period. The considerable volume of patients, in addition to the standard problems associated with implementing any new health plan, prompted the BC/BS IPA to delay contracting with MediCap. In addition, Blue Choice preferred to concentrate on regaining Blue Cross/Blue Shield's share of the employer group market, rather than phasing in a new population of Medicaid patients.

Blue Choice enrollment has since grown to 100,000 members in the six county service area, with 1,400 participating physicians. Yet,

this membership figure represents enrollees from only 250 out of a possible 6,000 employer groups. Current efforts are therefore focused on broadening the IPA's employer group base. Blue Choice representatives state they expect to eventually contract with the MediCap demonstration, but that this will not be feasible until sometime in 1987. It is worth noting, however, that because Blue Choice is an "open-panel" IPA, many of its physicians are affiliated with other provider groups and thus may already be participating in the MediCap demonstration through RHN.

Preferred Care stated at the outset it would not be willing to contract with the MediCap demonstration. The IPA cited its reasons for refusal in an October 1984 letter to MediCap executives. Some of the significant issues that were outlined in the letter include:

- o inadequate capitation amounts
- o no allowances for providers' administrative expenses
- o overly extensive mandated benefit package given the target capitation rates
- o unacceptable encounter data requirements, which were also incompatible with existing data systems
- o uncertainty over disposition of reinsurance funds
- o designation of MediCap as final authority over grievances and internal QA and UR programs

Because Preferred Care has just received federal certification for a Medicare risk contract, however, it is considering participation in the long-term-care component of the demonstration. It will also continue to monitor the progress of the AFDC-HR program phase-in and may eventually choose to contract with the plan if the issues outlined above can be resolved.

B. Phase II: Medically Needy Population

The protocol for Phase II of the demonstration, which includes the medically needy under age 65 and children in foster family care is currently being reviewed at the state level in the Department of Health and the Department of Social Services. Approximately 7,700 individuals in the county meet the medically needy eligibility criteria.

There are two issues that are being discussed with regard to this protocol. The first issue concerns the rates of payment. Originally, state officials wanted the ratesetting methodology for the medically needy group to be consistent with the methodology used for the cash assistance population. Thus, MediCap officials believed that the protocol was being held on the back burner until the cash assistance rates were finalized and approved. But now that the methodology for the 1986 AFDC and HR rates has been agreed upon, the state is proposing that the medically needy rates be calculated using the methodology that is employed for other Medicaid prepaid health service plans in the state. According to state officials, this methodology would incorporate changes in both prices and utilization, rather than relying solely on CPI proxies and changes in the Medicaid fee schedules to trend the rates through 1986. MediCap would like to stay with the methodology used for the cash assistance group. Hence, the state and MediCap have reached a stalemate in their discussions over this issue.

The second issue centers around those individuals who become eligible for the medically needy category of assistance by meeting the spend-down requirement. These are persons who are not eligible for public assistance, but who incur medical expenses that effectively

bring their income below 133.33 percent of the AFDC needs standard. Once the individuals have "spent down" to this level, they are then eligible for Medicaid. According to MediCap officials, this group is comprised of approximately 700 individuals and accounts for \$400,000, or approximately 10 percent, of the total fee-for-service expenditures for the medically needy population.

There are two types of persons who meet the spend-down requirement. First, there are those who incur a one-time medical expense that allows them to become eligible for Medicaid for at least a three month period. MediCap has proposed that these individuals remain in the fee-for-service system because they are not appropriate candidates for case management.

The other type of spend-down involves those who have recurring medical expenses that cause them to meet the spend-down requirement on a regular basis. These can include, for example, families with young children or persons who, because of a chronic condition, have recurring medical needs. These individuals may be good candidates for case management; a managed care program could control their medical expenses by linking these patients to physician case managers who would provide on-going supervision for the appropriate and cost-effective delivery of health care services.

MediCap is proposing that those individuals with a spend-down requirement which does not exceed the monthly capitation rate be enrolled in MediCap. (Those whose spend-down amount is greater than the capitation rate could still enroll in the program if they paid the capitation rate themselves.) MediCap will send the HMO a capitation payment for each enrollee, and it will be the HMO's responsibility to

collect the spend-down amount from each enrollee. At this time, MediCap is assuming that persons enrolling in the program through the spend-down provision will be guaranteed six months of Medicaid eligibility. Those enrollees though who fail to remit their spend-down amount to the HMO for two consecutive months will be disenrolled from the MediCap program in order to protect the HMO from financial loss. The state is still in the process of considering this proposal.

C. Phase III: 65 Years and Older Population

MediCap, Inc. plans to eventually enroll the entire Medicaid population in its prepaid, managed care demonstration. Beneficiaries aged 65 and older will be the third group to be phased into the program; enrollment of these eligibles is currently projected to begin in April 1987.

MediCap planners developed a long-term-care protocol that was submitted to the state for review and approval in October 1985. It also issued approximately ninety "requests for qualifications" to Monroe County providers in August 1985. MediCap subsequently received thirteen responses from interested health care groups, six of which expressed interest in contracting the project. Participating LTC providers will be required to be Medicare-certified so that they can contract for prepayment (i.e., be federally-certified HMOs), or to have a contractual agreement with an HMO that has received the federal certification. They will also have to demonstrate their ability to manage and provide for all the health care needs of MediCap enrollees.

Under the guidelines of MediCap's long-term-care proposal, Medicaid eligibles aged 65 and older will be enrolled in capitated, managed care plans. These plans will be operated by HMOs, or newly configured HMO-like entities, called Long Term Care Management Agencies (LTCMAs). MediCap will sign up eligibles in much the same way that AFDC and HR populations are currently enrolled in the demonstration.

Because nursing home patients generally use a disproportionate share of health care resources, MediCap will establish two cohorts to help prevent "cream skimming" and adverse selection. Assignment to the

cohort groups will be based on the site of care at the time of enrollment: nursing home patients will comprise one cohort, and all other Phase III MediCap enrollees, including home health care patients, will be assigned to the other cohort group regardless of health care delivery setting.

MediCap planners will determine the ratio of nursing home to non-nursing home patients in Monroe County (approximately 1:3) and will require each LTCMA to enroll patients proportionately. Thus, if an agency has signed up three lower-risk patients, it must enroll a nursing home client before it will be allowed to admit any more non-institutionalized patients. MediCap will monitor LTCMA compliance, and will establish waiting lists for MediCap beneficiaries selecting an agency that does not currently meet the program's enrollment ratio requirements.

After the beneficiary has chosen a particular LTCMA, he will then be required to select a case manager who is affiliated with that agency. Medicaid recipients who are also eligible for Medicare (approximately 90 percent of the 65+ population) will be simultaneously enrolled in Medicare risk contracts at the time of provider selection. The LTCMAS will be responsible for coordinating and maximizing dual eligibles' benefit coverage under the two assistance programs.

The agencies will receive a capitation payment for each enrollee and will be placed at financial risk for the delivery of all Medicaid-covered services, including institutional long-term care. The LTCMA will be responsible for authorizing or providing all necessary services (either directly or on a contract basis), and for monitoring and ensuring the delivery of appropriate, high-quality care.

MediCap's capitation rates for the aged will be calculated, on an actuarial basis, by dividing historical Medicaid payments for the 1983-1984 base year by total member months of eligibility, and trending these rates forward to the current year. MediCap will then deduct 5 percent from these amounts to achieve an initial savings in federal, state, and county expenditures. It will also deduct an additional 1 percent to cover MediCap's administrative expenses.

The remaining 94 percent of the adjusted Medicaid fee-for-service schedule will form the MediCap-to-LTCMA target rates. Capitation payments will be based on actuarial class only; no adjustments will be made for patient acuity or the site of health care delivery. Although MediCap planners are still in the process of developing specific contract provisions, it has been proposed that providers be allowed to bid for higher or lower payment rates based on the amount of risk they are willing to assume. Actual program savings which are ultimately achieved will, therefore, be determined by the bidding process.

Risk is defined on two levels -- on an aggregate and an individual patient basis. Aggregate risk is the total amount of losses a LTCMA can absorb in providing care to its enrollees before the stop-loss mechanism is activated. MediCap will require every contracting LTCMA to establish aggregate stop-loss coverage primarily to protect MediCap in the event of a LTCMA's bankruptcy or withdrawal from the project; the insurance fund will enable MediCap to purchase traditional health care coverage for the management agency's clients until they can be placed in a new or existing LTCMA. This requirement can be satisfied in any of the following ways: 1) by purchasing stop-loss coverage from a third-party insurer; 2) by contracting with MediCap to provide

this coverage through a risk pool it will fund with negotiated withholds from the capitation payments; or 3) by demonstrating sufficient reserves to meet potential aggregate losses.

MediCap will also establish a voluntary stop-loss insurance fund if two or more LTCMA's so agree. The fund is intended to protect LTCMA's that provide cost-effective care within the ceilings set by the capitation payments, but which incur significant losses from serving a catastrophically ill patient. This pool will be funded by negotiated percentage reductions from the MediCap-to-LTCMA capitation payments as determined during the bidding process. If the stop-loss fund's resources are depleted, the LTCMA's will assume liability for any outstanding claims. Should a provider wish to receive the maximum capitation allowable, it can opt out of the pool and assume full financial risk.

The base year and rate setting methodology will remain unchanged for the first five years of implementation to ensure financial and programmatic stability for all parties involved in the demonstration. MediCap, Inc. will continue to act as fiscal intermediary between the state and the health care provider groups.

New York state officials are concerned about the 65-years-and-older component of the MediCap phase-in process because of the high costs associated with the delivery of long-term care. This concern has been intensified by the current move in New York to transfer principal county share responsibility for LTC costs to the state. Originally, the county and state shares were split 25/25 (with the federal government responsible for the remaining 50 percent). The counties had been having difficulty covering Medicaid costs, however, since property

and sales taxes were their only sources of revenue. Because the state has access to greater resources from income and business taxes, the counties petitioned it to provide some fiscal relief. The state began assuming a larger portion of LTC costs in January 1983, and by January 1986 the phase-in process had been completed. State and local shares are now set at 40/10 respectively.

There are two primary issues that still must be resolved before the state authorizes the long-term-care component of the MediCap demonstration. The first involves the protocol for Medicare/Medicaid crossovers. Under the proposed system, the possibility exists for a LTCMA to receive two overlapping capitation payments for one patient. Ordinarily, there is no duplication of service coverage between Medicare's and Medicaid's benefit packages. The more comprehensive Medicare risk contract does include some services, however, that are already paid for by the Medicaid program.

State officials maintain that the fundamental issue is how to achieve a coordinated set of Medicare/Medicaid benefits that accurately reflects cost sharing. They believe there are two possible options:

- 1) deduct from the rate calculations the costs of overlapping services that were paid for by Medicaid during the base year period and which will now be covered by the Medicare supplemental plan purchased for MediCap enrollees, or;
- 2) leave the costs of these services in the base year calculations and offer a minimum Medicare benefit package that excludes supplemental benefits.

Conversely, MediCap planners believe the extended Medicare risk contract package should be adopted, and the costs of overlapping services included in the base year calculation process. They argue that although there would be some gains made from the dual payment for

selected services, this would be more than offset by the added costs associated with Medicare risk contract premiums (which would be paid by the LTCMAs).

The second issue concerns the amount of nursing home care that should be included in the demonstration's benefit package. MediCap has proposed that all nursing home care and nursing home residents be included in the plan since this represents the majority of Medicaid expenditures (approximately 53 percent of Monroe County's Medicaid budget). State officials say they agree all nursing home residents should eventually be enrolled in the demonstration. They became more cautious, however, after discussions were held with Monroe County HMOs. (These providers are central to Phase III because of the federal certification requirements). According to the state officials, representatives from these HMOs were concerned over this component of the MediCap program because there has been very little experience in risk management for the nursing home population.

State officials would prefer, therefore, to establish a time limit on the number of nursing home days that would be covered. They have proposed initially restricting enrollment to non-nursing home eligibles and, in cases where these individuals subsequently require nursing home care, setting a limit on the number of nursing home days that will be covered in the capitation. This, they believe, would give providers the chance to gain experience with managing health care for the elderly, and also help mitigate potential risks. Nursing home residents could then be gradually phased into the program and the time limit on nursing home days extended to a point where an analysis of the data shows maximum savings can be achieved.

This plan would result, however, in many nursing home residents eventually being excluded from the demonstration once they had exceeded their limits, and reverting back to Medicaid fee-for-service coverage. MediCap planners are concerned that this might create a perverse incentive for providers; patients may be referred to a nursing home even when home health care would be a viable option because, once they revert to fee-for-service, the provider will no longer be at financial risk to deliver services. Thus, MediCap officials stress the importance of enrolling all aged Medicaid beneficiaries in the prepaid, case management plans if any significant savings are to be made in program expenditures. The state maintains, however, that the number of nursing home days covered under capitation would be large enough (e.g., 60 to 120 days) to discourage providers from placing patients in these facilities merely so that they would eventually revert to fee-for-service coverage.

Although the state and MediCap are still negotiating resolutions to these outstanding issues, they sent an application to HCFA in November 1985 asking for an extension of program waivers (which are due to expire in April 1988). MediCap officials believe it will be important to receive a five year waiver extension from the date that enrollment of the 65+ population begins (mid-1987) if the Phase III project is to be adequately tested. They state that if the extension cannot be obtained through this process, they will seek alternative federal (HCFA) approval -- and the MediCap program would then function under New York's state Medicaid plan.

CHAPTER FIVE

CONCLUSIONS

Evolution of the MediCap Plan

The extended planning process that finally led to the implementation of the MediCap plan reflects the challenges involved in designing an innovative Medicaid program. Developing a consensus among the major parties involved in the demonstration -- the state, the county, MediCap, Inc., and area providers -- proved to be a difficult task. In particular, negotiations between MediCap and the state were protracted as each side emphasized their own priorities and concerns.

In its present form, the MediCap program lacks the basic elements of true competition. Although the planners originally sought to develop a program that would include participation by a broad base of providers ranging from individual physicians to already-established HMOs, only one HMO has joined the plan thus far. GVGHA will contract with MediCap in the near future, but they want to limit their enrollment to 1,000 Medicaid patients. Essentially, RHN has already cornered the market. The largest portion of the Medicaid population (AFDC and HR eligibles) will have already signed up with RHN providers by the time that GVGHA is prepared to accept any additional enrollees.

The program also deviates from the competitive model of health care financing in that it does not include any incentives for Medicaid recipients to choose a lower-cost plan. In effect, the Monroe County

Medicaid demonstration is simply testing the ability of prepaid health plans to reduce the cost of providing care through case management techniques, rather than through introducing any elements of competition into the health care marketplace itself.

It is worth noting, however, that although the demonstration has not engendered competition among the existing HMOs in the county as intended, there is some indication that competition is developing among RHN's affiliated providers for Medicaid enrollees. This will be an important area to watch as the demonstration progresses.

One of the state officials' primary concerns during the planning process was that Medicaid enrollees have a wide range of provider types from which to choose. It should be pointed out that this goal seems to have been met, even though only one HMO is currently participating in the program. Because RHN has an extensive provider network, it does not appear that Medicaid beneficiaries' access to a variety of providers has been unduly restricted as a result of the demonstration.

Implementation of the Medicaid Plan

The transition from theoretical design to actual program operations inevitably gives rise to unanticipated problems. The ability to respond to implementation issues in a timely manner is essential to building and maintaining the trust and commitment of the providers involved. Observers of the program have been critical of Medicaid, Inc.'s performance in this area. This will continue to be an important issue as the program expands to include another HMO and the medically needy population. Problems that do not receive adequate

attention are likely to have a negative impact on both program operations and participants' attitudes.

Clearly defined roles and responsibilities, as well as open lines of communication among all administrative levels, are also crucial in the start-up phases of a new program like MediCap. Lack of communication within the multi-tiered administrative structure of the MediCap Plan has, in some cases, inhibited the effective resolution of program difficulties. A major issue cited by affiliated providers has been whom to hold accountable for ensuring the efficient operation of the MediCap demonstration.

Finally, a fully functioning management information system is an integral component of any incentives-based case management program. Providers need accurate and timely information about what patients are assigned to them, as well as information that allows them to track the care that these patients are receiving. They also require regular and current reports on the balances in their capitation fund accounts if they are to both manage their financial risk successfully and respond to the incentives structure of the program.

Future Developments

Many providers expressed a commitment to the concept and objectives of the MediCap program. They believe it has cost-saving potential as well as the ability to offer better continuity of care to Medicaid beneficiaries. They have been frustrated, however, by the various start-up problems described in this report. It appears that the ultimate success of the program will depend on the ability of

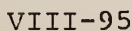
MediCap and RHN to cooperate with providers and with each other in responding to concerns at the provider level.

As the program moves into its second year of operation, it will be important to evaluate the following areas:

- o development of competition among RHN affiliated providers for MediCap enrollees;
- o changes in provider practice patterns in response to the MediCap program;
- o outcomes of utilization review and quality assurance activities;
- o the effects of bringing another HMO into the demonstration;
- o whether the capitation rates are adequate.

Monroe County's intention to enroll all Medicaid beneficiaries aged 65 and older in prepaid, managed health care plans is of particular interest. This group presents unique challenges in terms of determining appropriate risk arrangements, and providing and financing care for Medicare/Medicaid crossover cases. Only one of the other demonstrations has attempted to capitate long-term care services. The state and MediCap are venturing into new territory, and it will be interesting to see the end results of their efforts to integrate this high-cost population into a prepaid, managed care system.

Organizational Roles Under MediCap



APPENDIX B

RHN Affiliated Providers

<u>Health Centers</u>	<u>Option Chosen</u>
Canandigua *	not applicable
Eastside *	not applicable
Family Health	Option I
Genessee	Option III
Jordan	Option II **
Northeast	Option II
Oak Orchard	Option I
Riverton	Option I
Westside	Option II **

IPA

Monroe Plan	Option II
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Hospital/Medical Staff

Highland Health Care	Option II
Rochester General	Option II
Strong Memorial	Option II
St. Mary's	Option I

* These two health centers are not participating in the MediCap program.

** These two health centers originally chose Option I, but decided to switch to Option II as of 1/1/86.

APPENDIX C

Description of MediCap Benefit Package

Covered Services

Physician Services
Services Provided in Hospital Out-Patient Departments
Services Provided in Diagnostic and Treatment Centers
Laboratory Services
Radiology Services
In-Patient Hospital Services
Transportation
Rehabilitative Therapies
Emergency Services
Medical Supplies and Equipment
Home Health Services
Mental Health Services
Physical Therapy
Speech Pathology
Occupational Therapy
Family Planning and the Full Range of Reproductive Health Services
Podiatry Services
Renal Dialysis
Prescription and Non-Prescription Drugs
Personal Care Services
Audiometric Services
Routine Vision Care

Uncovered Services

Skilled Nursing or Health-Related Facility Care
Dental Services
Medically Necessary Cosmetic Surgery for Correction of Effects of
 Injury or Disease
Methadone Maintenance
Child Caring Agency Services
Office of Mental Health/Office of Mentally Retarded/Developmentally
 Disabled and Family Care Services

**U.S. Department of
Health and Human Services**
Health Care Financing Administration
Room 1-A-9 Oak Meadows Bldg.
6325 Security Boulevard
Baltimore, MD 21207



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Office of Research and Demonstrations
HCFA Pub. No. 03236 September 1986